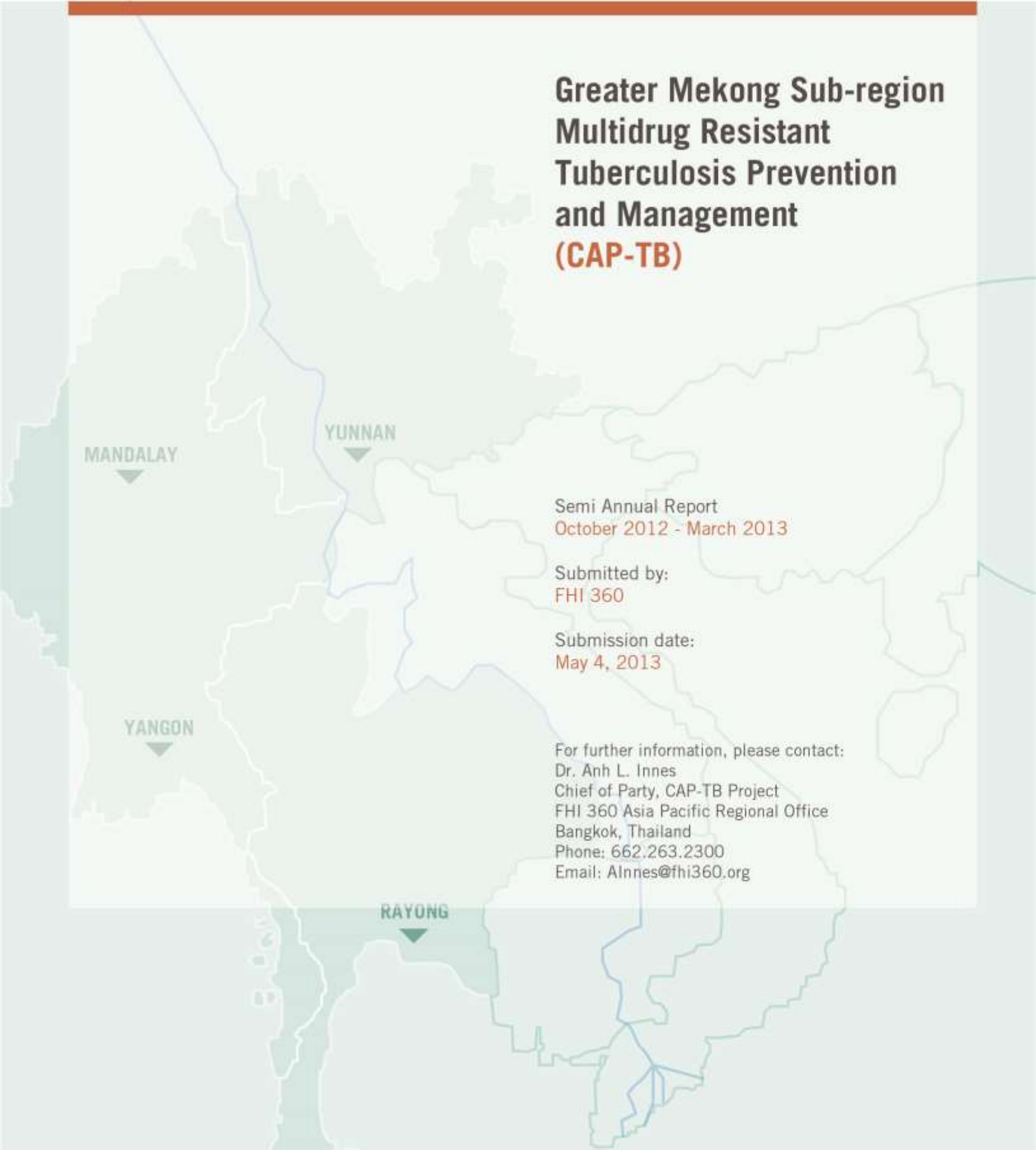
Greater Mekong Sub-region Multidrug Resistant Tuberculosis Prevention and Management (CAP-TB)



Semi Annual Report
October 2012 - March 2013

Submitted by:
FHI 360

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CAP-TB
CONTROL AND PREVENTION OF TUBERCULOSIS

fhi360

Table of Contents

BURMA

Period covered: 1st October 2012 to 30th March 2013

Acronyms

BHS	Basic Health Staff
CAP-TB	Control and Prevention of Tuberculosis (Greater Mekong Sub-region Multidrug Resistant Tuberculosis Prevention and Management Project)
FHI 360	Family Health International
FY	Fiscal year
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
IAs	Implementing Agencies
IEC	Information, education and communication
IR	Intermediate Result
MBCA	Myanmar Business Coalition on AIDS
MDR-TB	Multidrug resistant tuberculosis
MHAA	Myanmar Health Assistants Association
MMA	Myanmar Medical Association
NTP	National TB Control Program
PGK	Pyi Gyi Khin
PM	Program manager
PMP	Performance management plan
PSI	Population Services International
TA	Technical assistance
TB	Tuberculosis
TMO	Township Medical Officer
USAID	United States Agency for International Development
WHO	World Health Organization
WTB Day	World TB Day

Narrative I: Executive Summary

In Quarter 2 of FY13, implementation of the USAID RDMA-funded Control and Prevention-Tuberculosis (CAP-TB) project was under way with strong commitment, participation, and scale-up from the project's implementing agencies (IA). Finalization of the IA's sub-agreements and raising advocacy at local, regional, and national levels within the National Tuberculosis (NTP) network were critical steps in the start-up process. Although these steps were time-consuming, they have laid a strong foundation for the CAP-TB team to work successfully in close coordination with the NTP network.

The Myanmar NTP's strategic plan to scale up multi-drug resistant tuberculosis (MDR-TB) diagnosis and treatment is complex and requires coordinated participation from local and international partners for success. The country is currently in a critical period, during which rapid scale-up of MDR-TB control and prevention is necessary to prevent further transmission of the disease and the creation of more serious problems. These problems include extensively drug-resistant TB and total-drug resistant TB, both of which are growing epidemics in countries such as China and India. The NTP has been very successful in treating MDR-TB in its first phase of MDR-TB implementation, which was focused in 22 townships in Yangon and Mandalay: the treatment success rate of 71% among MDR-TB patients who have already failed two regimens is impressive and far better than the global average of 48%. The NTP has also scaled up its MDR-TB townships to a total of 38 with support from CAP-TB and other organizations, with plans for further scale-up to 62 townships in this calendar year. Although this scale-up plan appears rapid, the geographic coverage is still sub-optimal in light of the country's > 320 townships. Additionally, there are currently more than 2000 patients already diagnosed with MDR-TB who are on waiting lists for treatment.

Given the large gaps in capacity as well as the continuing gaps in funding, the project's contribution to the NTP's MDR-TB strategic plan is significant: nutritional and living support of patients is critical to the success of the MDR-TB treatment, and such support must go hand-in-hand with second-line drug administration. Working in close coordination with the NTP, the WHO, and other partners and donor organizations in Burma will be necessary to ensure that the thousands of patients who have MDR-TB will receive life-saving care. The CAP-TB team in country is led by the FHI 360 Burma Country team as prime cooperating agency; implementing agencies are the Myanmar Medical Association (MMA), Myanmar Health Assistant Association (MHAA), Pyi Gyi Khin, (PGK), and Myanmar Business Coalition on AIDS (MBCA).

Narrative II: Challenges encountered during reporting period

Implementation of the project's activities was delayed; however, since start-up has commenced, the CAP-TB IAs' progress has been rapid, and the team projects that implementation will exceed expectations once activities are in full force. Reasons for delay in implementation include the following: first, PGK and MBCA were new as partners to the National TB Program (NTP), thus receiving official approval from NTP to begin implementation required necessary steps. The need to secure approval for the "Notwithstanding Authority Memo" for Burma also delayed implementation, as many activities in the Burma work-plan required assistance to the government.

Subsequent to the NWA Memo's approval, additional concurrence from the USAID Burma mission must also be obtained for supporting Burma government officials to participate in training and technical assistance; an initial advocacy meeting requiring this approval has therefore been postponed until April 2013, and it will be reported in the Annual Progress Report.

Under the current budget, nutritional support is available only in project coverage areas (four townships in Yangon and four in Mandalay) but this is insufficient to meet the needs of the growing number of MDR-TB patients in the area, particularly given that 3 Disease Fund (3DF) nutritional support will end April 30, 2013. Requesting an increased budget ceiling for the IAs will therefore be necessary should the project be asked to increase its support of the NTP's MDR-TB scale-up plan.

Finally, CAP-TB reporting requirements are not aligned with NTP processes: the project requires additional data disaggregation that is not currently part of NTP reporting (by population group, provider types, for example) resulting in additional training and monitoring of IA staff and generating a significant amount of data for consolidation and management. A project database is being developed; however, in the meantime project staff must collate and manage data using paper forms.

Narrative III: Program Performance during reporting period

IR1: Strengthened MDR-TB prevention

Output 1.1: Mobilized communities to advocate for and use TB service

Activity 1.1.1 Conduct training on TB and MDR-TB for staff from CAP-TB partner organizations to support the CAP-TB strategic model implementation

From March 4-6, the FHI 360 Burma office trained 16 field staff of CAP-TB partner agencies (USAID PMP Indicator 17) to effectively implement TB/MDR-TB community outreach. Training objectives included teaching field staff how to do the following:

1. Provide basic knowledge on TB and MDR TB management (prevention and transmission, care for patients and infection control)
2. Promote early case detection and referral
3. Enhance community awareness through health education and home visits
4. Conduct day-to-day data recording and reporting

Activity 1.1.2 Conduct community outreach activities in project sites to support implementation of the CAP-TB strategic model

During this reporting period, CAP TB partners conducted community outreach activities in 11 townships, where they distributed a total of 6,823 pieces of IEC material (6,060 pamphlets, 262 posters, 259 t-shirts and 242 caps). The partners reached a total of 675 beneficiaries (USAID PMP Indicator 9) with information on TB signs, symptoms and treatment; referral to available health services; and the importance of treatment adherence.

The CAP-TB team began conducting home visits and providing nutrition packages for MDR-TB patients from 1 April (technically FY13 Q3).

CAP-TB IAs supported joint visits to MDR-TB patients conducted by outreach workers (ORWs) and Basic Health Staff (BHS). During these daily visits, BHS provided medication while ORWs conducted contact investigations and provided patients with nutritional support, inflection control education and drug adherence counseling. These joint visits are intended to harmonize support for MDR-TB patients and ensure sustainability continuity of care.

Activity 1.1.3 Screen all employees under MBCA businesses for TB and link with Township Health Centers for referrals to support CAP-TB strategic model implementation

MBCA conducted small group discussions on general TB knowledge and TB signs and symptoms in factories within Monywa industrial zone. These discussions were aimed at encouraging screening of employees with symptoms of potential TB infection, advocating for workplace TB policies, providing TB/MDR-TB IEC materials, and linking workers to TB services at the MBCA non-profit clinic and nearby township health centers. During this reporting period, 172 factory workers participated in discussion sessions and MBCA provided 4 referrals and all had been taken up as of the writing of this report.

Activity 1.1.4 Commemorate World TB day with activities to advocate for TB services

FHI 360 and local CAP-TB IAs participated in World TB Day activities in close collaboration with NTP. These activities aimed to promote TB/MDR-TB services in selected townships through:

1. Distribution of IEC materials (pamphlets, caps, t-shirts and posters)
2. Speeches by key stakeholders (including TB patients, community leaders, Township Medical Officers, and local government representatives)
3. Presentations on TB epidemiology in Burma and in the world, the fight for TB elimination, infection control advocacy
4. Photo exhibitions of community outreach TB activities and DOTs providers

The World TB Day activities organized by CAP-TB partners drew a total of 339 participants, including stakeholders and beneficiaries. MMA World TB Day activities were postponed until April (Q3) so that key personnel from NTP and the Yangon Regional Health Department could be involved.

Output 1.2: Scale-up implementation of TB infection control in health facilities

Activity 1.2.1 Strengthen TB-IC in health facilities, households, and communities

Official home visits to MDR-TB patients started in Q3 because of the delay in preparing the nutrition package provided under CAP-TB (reasons mentioned above in the challenges). While awaiting delivery of the nutrition package, the CAP-TB core (FHI 360) team developed a draft Quality Assurance (QA) checklist for infection control which was reviewed by technical staff at the FHI 360 Asia Pacific Regional Office.

Using the QA checklist and referencing the CAP-TB Thailand's checklist, the CAP-TB team developed an infection control checklist for outreach workers to use during home visits. This check list is one component of home-based care to MDR TB patients' households within the 8 townships covered by MHAA (Mandalay) and PGK (Yangon). IA staff members will administer the check-list and apply the guidance provided in the CAP-TB Infection Control guide, with the goal to prevent TB transmission in MDR TB patients' households. The three goals of TB infection control include: 1) Administrative controls 2) Environmental controls and 3) Personal Protection Equipment. See Annex 1 for the full infection control check-list.

IR 2: Strengthen MDR-TB management

Output 2.1: Ensured capacity, availability, and quality of laboratory testing to support the diagnosis and monitoring of TB patients, including the rapid diagnosis of MDR-TB

Activity 2.1.1 Procure GeneXpert machine and consumables

FHI 360 will procure a GeneXpert machine for use by CAP-TB partners at the Lower Myanmar TB Center. As of the time of writing this report, the team has received approval from the MOH International Health

Department with the expectation to finalize the purchase order, followed by shipment within the next weeks (estimated delivery date within May 2013).

Output 2.2: Strengthened case-finding and referrals for MDR-TB

Activity 2.2.2 Provide education to members of populations at high risk for MDR-TB

Outreach activities were conducted by CAP-TB IAs in collaboration with the NTP to promote early MDR-TB case detection among high-risk populations (individuals in close contact with MDR-TB patients). These activities are described above under IR1 (above).

Activity 2.2.3 Strengthen referral linkages for MDR-TB suspects and patients between concerned service providers

CAP-TB implementing agencies strengthened referral linkages for patients at risk for MDR-TB as one component of outreach activities and advocacy activities. These include strengthening referral linkages for treatment failure patients, treatment defaulters, patients who remain smear positive at two months, people in close contact with known MDR-TB patients, and people living with HIV (PLHIV). Four individuals were referred by MBCA outreach, and all patients accessed a mobile X-ray team and/or the NTP for TB diagnosis. The successfully referred individuals included 3 men (one elderly, one migrant, and one general population) and 1 woman (general population).

Output 2.3: Strengthened human resource capacity for MDR-TB management

Activity 2.3.1 Conduct training for public and private sector General Practitioners (GPs) on Standard Treatment of TB and diagnosis of MDR-TB and Infection control (100 GPs to be trained in Mandalay and in Yangon)

MMA will conduct this activity with FHI 360 support during Q3 (Yangon in May and Mandalay in June).

Activity 2.3.2 Conduct training for Township Medical Officers in standard diagnosis of TB, x-ray reading, general clinical practice, infection control, community mobilization, financial management, data management

Training in chest X-ray Reporting and Recording System were conducted during October 2012 (1-3 Oct in Mandalay and 4-6 Oct in Yangon) by the NTP and the International Union Against TB and Lung Disease, with support from CAP-TB.

International consultants Dr. Greg Symons (Pneumologist, UCT Lung Institute, South Africa) and Dr. Calligaro Symons (Pneumologist, UCT Lung Institute, South Africa) conducted these three-day trainings in Mandalay and Yangon for a total of 57 participants (USAID PMP Indicator 17) (26 In Mandalay and 31 in Yangon) including public sector township medical officers and TB Team Leaders from 22 project townships and private sector general practitioners (32 from Public and 25 from Private).

Activity 2.3.3 Conduct TOT for MDR-TB clinical management training in 16 additional townships under the NTP expansion plan for MDR-TB

The National TB Program conducted a training-of-trainers (TOT) on programmatic management of MDR-TB (PMDT) from November 5-12, 2012. In total, 93 public and private sector participants attended the training (USAID PMP indicator 18), including focal points from each of the four CAP-TB implementing agencies:

1. MMA: 1 female staff from Yangon (Project guidance supervisor)
2. MBCA: 4 staff including 2 women from Yangon (1 Executive Director, 1 Assistant coordinator) and 2 men from Mandalay field office (2 Program Officers)
3. MHAA: 1 man from Yangon (President)

4. PGK: 1 man from Yangon (M&E Officer)

Following this TOT, all physicians, township medical officers and TB coordinators who attended the training will provide community based training to government Basic Health Staff. In upcoming quarters, the CAP-TB IAs will also organize an outreach worker training for 35 additional community outreach workers drawn from factories in the Moywa Industrial Zone who will become "TB Champions" disseminating TB prevention and treatment messages and providing referral assistance in their communities.

Output 2.4: Scaled-up quality treatment and community approached for PMDT

Activity 2.4.1 Provide package of services to 200 MDR-TB patients

PGK and MHAA have completed procurement of nutritional support packages for project beneficiaries. Distribution of these packages has already begun, technically in Q3 thus the numbers will not be reported in this SAPR's PMP. However, to date, 179 patients (143 from 4 townships in Yangon Region and 36 from 4 townships in Mandalay region) have had the nutritional package of services delivered to their homes, starting from April 2013. The full package of services (nutritional support, transportation support, home infection control, adherence and adverse effects counseling) will be conducted on a monthly basis by PGK (Yangon) and MHAA (Mandalay) in support of the NTP's MDR-TB strategy.

IR 3: Improved strategic information for MDR-TB

Output 3.1: Strengthened capacity of TB programs to collect, use, and analyze data for management

Activity 3.1.2 Provide TA on the development of a national MDR-TB M&E system and database that is compatible with NTP to improve routine data collection, analysis and management

WHO is providing the main technical assistance to NTP for development of an M&E database. A WHO consultant made a first visit during the first quarter of FY13. The FHI 360 team will support implementation of the database when it is launched.

Activity 3.1.3 Strengthen Data Quality Assurance (DQA) and data analysis to Myanmar Medical Association (MMA), Pyi Gyi Khin (PGK), Myanmar Business Coalition on AIDS (MBCA) and Myanmar Health Assistant Association (MHAA)

The senior CAP-TB monitoring and evaluation (M&E) officer and program officers (POs) visited the Lower Myanmar TB Center and North Okkalapa Township health centers to introduce the CAP-TB project, advocate for data sharing, align NTP and CAP-TB reporting and data requirements, and study current practices in order to identify gaps and potential challenges.

FHI 360 also collected copies of all TB-related M&E forms currently being used by project partners, and introduced the CAP-TB forms. M&E related staffs from CAP TB partner organizations (2 men and 2 women) were supported to participate in a MEASURE M&E training held December 2012 in Bangkok (USAID PMP Indicator 20). Ms. Shanthi Noriega, FHI 360 APRO Associate Director, Strategic Information conducted a one-day M&E training for the CAP-TB Burma team and 8 M&E related staff from the CAP-TB IAs (USAID PMP Indicator 20).

In March FHI 360 Burma Senior M&E Officer Dr. Soe Htut Aung conducted monitoring visits to IA's remote field offices in Monywa and (Patheingyi) Mandalay.

Output 3.2: Increased TB research activities

Activity 3.2.1 Conduct community survey on consumer demand and health seeking/purchasing behavior for diagnosis, treatment and drugs

FHI 360 Burma launched the Trends TB module during this reporting period. FHI 360 staff trained IA field staff on Trends implementation from March 20-22, and data collection began on March 25 with an expected final sample size of 1,230 participants. The Trends survey data collection is projected to end on April 26 – this is one week later than in other CAP-TB countries because of the long Thingyan holiday in Burma. As of this reporting period, 100 total participants have been recruited to conduct the survey, and a total of 1,022 beneficiaries (410 MBCA, 410 MHAA and 202 PGK) have completed the survey.

IR 4: Strengthened enabling environment for MDR-TB control and prevention

Output 4.1: Improved capacity of NTPs to develop, finance, and implement national TB control strategies in line with global strategies

Activity 4.1.2 Enhance the integration/coordination of services at all levels in Yangon and Mandalay with other divisions

Local implementing agencies conducted advocacy and coordination activities with key stakeholders as detailed below, in order to generate support for the project. Additional regional level advocacy meetings are also planned for FY13 Q3.

A key component of enhancing the integration and coordination of services at all levels of the TB network has been the active participation of the CAP-TB staff in coordination and strategy meetings organized by the NTP, by the USAID Burma mission, and by the CAP-TB team itself.

Quarterly TB Technical Strategic Group meetings organized by NTP: these meetings are critical to the organization and implementation of the NTP's strategy, thus participation by the CAP-TB team has been an important way to integrate the team into the NTP's operations. Two meetings were held by the NTP during Q2, and both were attended by CAP-TB program officers.

Partner meetings organized by the USAID Burma mission: these meetings have laid the foundation for open communication and regular updates with the Burma mission on the project's activities. Two meetings during Q2 were held and attended by CAP-TB.

CAP-TB team meetings for implementing agencies and partners: these meetings focused on coordination among CAP-TB IAs and partners as well as monitoring and evaluation, conducted during site visits by the CAP-TB team. Seven meetings and site visits have been conducted during Q1 and Q2.

Monthly coordination meetings have been held for the CAP-TB IAs starting in December 2012. These meetings have been important to communicate key messages to the IAs, to build team unity among the CAP-TB team, and to train IAs on different components of the project, including training of outreach workers; training on the TB Trends survey; and training on the community infection control check-list for home visits.

Lastly, regular coordination visits have been conducted by the CAP-TB with partners in Yangon (Lower Myanmar TB Center) and Mandalay (Upper Myanmar TB Center). During these visits, review of the NTP reporting/referral forms is made by the CAP-TB M&E officer, helping to facilitate the process for collecting project data.

Output 4.2: Strengthened partnerships for quality TB care, including private sector

Activity 4.2.1 Build the organizational capacity of national partners (MMA, MBCA, MHAA and PGK)

FHI 360 APRO Consultant Mr. Siddhi Aryal conducted an organizational capacity assessment for all local IAs from January 8-11, facilitated by the CAP-TB Burma team. FHI 360's Organizational Capacity Assessment Tool (OCAT) was used to assess capacity in terms of governance, administration, human resources management, financial management, organizational management, program management, and project performance management. A total of 14 representatives (7 men and 7 women) from private sector NGOs participated in the assessment.

According to the OCAT, following areas were prioritized by the IAs as shown in the table below:

	AREA 2 Administration	AREA 3 Human Resource	AREA 5 Organizational Management	AREA 7 External Communication
MMA	**3**	**2**		**1**
MHAA		**3**	**2**	**1**
MBCA		**3**	**2**	**1**
PGK		**2**	**3**	**1**

The recommendations for action plan according to each specific priority areas were discussed in detail, including the objectives, evidence of achievement, activities, resources needed, responsible persons and also the time frame. The follow up activities will be done according to the work plan and a local consultant will also be hired to fill the technical gap. Please see Annex 3 for summary report of baseline Organizational Capacity Assessment.

Activity 4.2.2 Advocate with employers of large companies to have workplace policies, provide TB/MDR-TB health education and TB screening for employees

During this reporting period, MBCA engaged in informal advocacy meeting with the industrial zone management committee and factory owners to conduct awareness raising sessions with factory workers. The planned advocacy meeting with higher level stakeholders will be held in April 2013.

Narrative IV: Snapshot

Recruiting TB Champions for Burma

Monywa is the largest capital in the north western part of Burma, an area booming with business potential. Workers migrate from neighboring regions to work in Monywa's industrial zone. There are many factories populating the area, and men and women of all ages from different communities can be found here. The Myanmar Business Coalition on AIDS, a CAP-TB implementing agency, is working on community TB prevention activities in this industrial zone.

Mya Mya is married to the owner of one small timber factory, where workers fashion Burmese timber into decorative wooden boxes. MBCA conducted health education sessions in this factory. After the training, participants were asked to volunteer as "TB Champions." Like most workers and factory owners, the workers thought that TB was not their concern as long as they stayed healthy and were able to work. From the participants' silent response, it was clear that no one was willing to be a TB Champion, viewing it as a waste of time and a distraction from their daily work.

The CAP TB outreach worker recognized the challenge and started asking questions. “OK, nobody wants to be TB Champion, then who wants to be a TB patient?” The answer, of course, was that no one wanted to be a TB patient. The CAP-TB outreach worker continued. “So if you do not want to be a TB patient, how many ways can you prevent TB infection?” The workers used what they had learned during the Health Education session: “TB is an airborne disease, and it is all around us."

The workers were informed about the chance of becoming infected with TB and developing active disease through breathing in the TB microorganisms. Then, a possible solution to TB infection was introduced: case finding and effective treatment. The concept was explained using simple figures showing the possible threat of the disease through an undiagnosed, active TB patient in the community.

After the discussion, the workers realized that even one single TB patient could place a community at risk. Mya Mya was nominated by the factory workers to be the TB Champion, representing the factory to advocate for fighting against TB in Monywa.

Annex I: Infection Control Checklist for TB and MDR TB patient households by ORW-Burma

Client-focused activities	Yes	No	NA/Unknown	Actions/Comments
Does the TB patient take the DOT in front of the caregiver to enable the continuous treatment?				If not, describe the problem and mention the importance of continuous treatment to the team
If yes, specify directly observed therapy (DOT)				
Self-medication				
Monitoring the medication by family member				
Monitoring the medication by VHV or NCCM staff at home)				
Monitoring the medication by health care worker at the health facility				
Others (Please specify)				
The patient tells other family members that he is suffering with TB.				If not, describe the pros and cons of the disclosure
Other members have cough symptoms. If yes, ask how long the symptoms have persisted.				If cough symptoms last more than two weeks, recommend that the family members take the TB screening test at the health facility
Number of family members who share the same house with the patient is ..... persons. Child less than 5 years old..... person (s) Elder ..... person (s) Pregnant woman ..... person (s)				
Have the family members passed the TB screening? If yes, no. of person .....person (s)				
Type of TB screening) multiple choices)				
Symptom diagnosis by public health officers				
Sputum examination				
Chest X-ray				
Symptom evaluation				
In case of children, has the person taken the Tuberculosis Skin Test (TST)?				
The patient can demonstrate how to cough hygienically.				If not, ask him to demonstrate how to cough hygienically.
If yes, does the patient do the following:				
Cover his mouth with a handkerchief/ tissue paper				
Cover his mouth with his arm				
Does the patient know how long he/she needs to wear the mask?				If not, educate to wear during intensive phase of any treatment.
Do Household members/caregivers know how long he/she needs to wear the mask?				If not, educate to wear during intensive phase of any treatment.

Client-focused activities	Yes	No	NA/Unknown	Actions/Comments
Does the patient know how to safely dispose sputum?				If not, teach him the proper method.
While the culture result is positive, the patient can spread TB to others in the first 2-3 weeks of the treatment. The patient knows how to reduce the risk of TB spread while he is in the period of communicability.				If not, teach him how to prevent it from spreading to others.
Example: Joining an outdoor party in the period of communicability (or until the culture is negative) Greeting neighbors from the area outside the house instead of the area inside If possible, avoid the crowded travel method.				
The patient knows how to reduce TB spread when meeting guests or visitors is unavoidable (A guest means those who are not family members)				If not, teach him how to prevent the spread to others.
Example:				
Have the patient relax/ sleep in a separate room with closing door Open doors and windows Cough hygienically				
Patient's family members understand the importance of ventilation and help open the windows during the day.				Teach him the importance of good ventilation to help lessen TB spread
The patient was diagnosed with HIV.				If no, send the patient to a clinic to get advice and bloodletting. If yes, get rechecked if it is more than 6 months ago.
If the patient was diagnosed with HIV, please verify whether it's documented or not.				If the result is negative, continue to support him to ensure he does not get infected. If the result is positive, check if the patient needs to receive the services here or somewhere else
A family member of the patient has been diagnosed with HIV.				If not, describe and point out the benefits of HIV diagnosis.
Does the affected person know the HIV result?				
The HIV caregiver knows that the HIV patient is in contact with the TB patient.				If the HIV result is positive, suggest that he goes for the TB screening test at the health facility and if possible, give Isoniazid to prevent TB.

Environmental issues to be observed at each visit	Yes	No	NA/Unknown	Description
Windows are installed at the patient's house.				
Doors and windows are open to ventilate the house as much as possible.				
The patient has many visitors.				
Only family members visit the patient.				
Such persons at risk are living in the same house as the patient:				
Child less than 5years old				
HIV patient				
Elder				
Pregnant woman				
Diabetes patient				

Personal Protection for Health Care workers	Yes	No	NA/Unknown	Description
When possible, you take the patient to collect his sputum in an open air location.				
If the patient is MDR-TB or XDR-TB, you wear a surgical mask during the communicability period. (During Intensive phase which is about 6 months for MDR TB and 2 months for TB)				

Annex II: Strengthened human resource capacity for MDR-TB management (FY12 Data)

In the last quarter of FY12, CAP-TB partner, the International Union Against TB and Lung Disease conducted trainings in Yangon and Mandalay under Activity 2.3.2. The full report of these trainings had not been made available to the CAP-TB team at the time of the APR, thus we now provide the full details from the training for reference purposes.

2.3.2 Conduct training for Township Medical Officers in standard diagnosis of TB, x-ray reading, general clinical practice, infection control, community mobilization, financial management, data management

Date	Name of Training	Venue	City	Participants	Trainers
03/09/12	Training of Standard Diagnosis and Treatment of TB for TMOs and GPs	Nadi Myanmar	Mandalay	TMOs, NTP and GPs	National Experts & External Experts (1,2,3)
04/09/12		Nadi Myanmar	Mandalay		
05/09/12		Nadi Myanmar	Mandalay		
06/09/12	Training of Infection Control, Advocacy, communication and Social Mobilization for Basic Health Staff	Nadi Myanmar	Mandalay	Basic Health Staff	National Experts & External Experts (1,2,3)
07/09/12		Nadi Myanmar	Mandalay		
08/09/12		Nadi Myanmar	Mandalay		
10/09/12	Training of Standard Diagnosis and Treatment of TB for TMOs and GPs	Summit Park View	Yangon	TMOs, NTP and GPs	National Experts & External Experts (1,2,3)
11/09/12		Summit Park View	Yangon		
12/09/12		Summit Park View	Yangon		
13/09/12	Training of Infection Control, Advocacy, communication and Social Mobilization for Basic Health Staff	Summit Park View	Yangon	Basic Health Staff	National Experts & External Experts (1,2,3)
14/09/12		Summit Park View	Yangon		
15/09/12		Summit Park View	Yangon		
01/10/12	CXR Reporting and Recording System	Nadi Myanmar	Mandalay	TMOs, NTP and GPs	External Experts (4,5)
02/10/12		Nadi Myanmar	Mandalay		
03/10/12		Nadi Myanmar	Mandalay		
04/10/12	CXR Reporting and Recording System	Latha NTP	Yangon	TMOs, NTP and GPs	External Experts (4,5)
05/10/12		Latha NTP	Yangon		
06/10/12		Latha NTP	Yangon		

Training of Standard Diagnosis and Treatment of TB for TMOs and GPs

Union Conducted TB trainings to the Public and Private Sectors: Township Medical Officers (TMOs), General Practitioners (GPs) from Myanmar Medical Association (MMA) and Medical Officers from the Union in Mandalay and Yangon. These 3 days trainings organized by NTP and the Union were done two times in Mandalay and Yangon in September 2012 (3-5 September in Mandalay and 10-12 September in Yangon). Three International consultants, Mr Subrat Mohanty(Project coordinator, the Union South East Asia Regional Office, New Delhi), Dr Subhash Yadav (Technical Officer, the Union South East Asia Regional Office, New Delhi) and Dr Ramya Ananthakrishnan (Project Director, Research group for Education and Advocacy) together with facilitators from National TB Program conducted the trainings. Total 62 participants (USAID PMP Indicator 17) including 28 participants (Male 8, Female 20) from Public sector, who were TMOs and TB Team Leaders from the 22 project townships. 34 participants (Male 16, Female 18) from Private sector Scheme 3 GPs from MMA and the MOs from the Union (Private sector) attended the three-days training which covered the Standard diagnosis and treatment, Infection control and ACSM (Advocacy, Communication and Social Mobilization) in TB.

Table 1: Training of Standard Diagnosis and Treatment of TB for TMOs and GPs

Indicator No	Indicator	Current	**Current Year Result**
Indicator 17	Number of individuals completing training in TB case finding approaches		
	Total		**62**
	Public		**28**
	Health Care Provider		**28**
	Male		**8**
	Female		**20**
	Community Health Workers		
	Male		
	Female		
	Others		
	Male		
	Female		
	Private		**34**
	Health Care Provider		**20**
	Male		**12**
	Female		**8**
	Community Health Workers		**5**

	Male		**2**
	Female		**3**
	Others		**9**
	Male		**2**
	Female		**7**

Training of Infection Control, Advocacy, communication and Social Mobilization for Basic Health Staff

Union also conducted TB trainings to the TB key persons and Basic Health Staff (BHS) of Mandalay and Yangon. These three-day trainings organized by NTP and the Union were conducted two times in Mandalay and in Yangon in September 2012 (6-8 September in Mandalay and 13-15 September in Yangon). Three International consultants, Mr Subrat Mohanty(Project coordinator, the Union South East Asia Regional Office, New Delhi), Dr Subhash Yadav (Technical Officer, the Union South East Asia Regional Office, New Delhi) and Dr Ramya Ananthakrishnan (Project Director, Research group for Education and Advocacy) together with facilitators from National TB Program conducted the trainings. Total 74 participants were trained, 59 participants (Male 7, Female 52) from Public sector including health assistant, nurses, lady health visitors etc., and 15 participants (Male 6, Female 9) from Private sector. Those trainings covered the Standard diagnosis and treatment, Infection control and ACSM (Advocacy, Communication and Social Mobilization) in TB.

Table 2. Training of Infection Control, Advocacy, communication and Social Mobilization for Basic Health Staff

Indicator No	Indicator	Current	**Current Year Result**
Indicator 17	Number of individuals completing training in TB case finding approaches		
	Total		**74**
	Public		**59**
	Health Care Provider		
	Male		
	Female		
	Community Health Workers		**59**
	Male		**7**
	Female		**52**
	Others		
	Male		
	Female		

	Private			**15**
	Health Care Provider			
	Male			
	Female			
	Community Health Workers			**7**
	Male			**4**
	Female			**3**
	Others			**8**
	Male			**2**
	Female			**6**

Summary table (Table 1 and 2)

Indicator No	Indicator	Current		**Current Year Result**
Indicator 17	Number of individuals completing training in TB case finding approaches			
	Total			**129**
	Public			**87**
	Health Care Provider			**28**
	Male			**8**
	Female			**20**
	Community Health Workers			**59**
	Male			**7**
	Female			**52**
	Others			
	Male			
	Female			
	Private			**42**
	Health Care Provider			**20**
	Male			**12**
	Female			**8**
	Community Health Workers			**11**
	Male			**5**
	Female			**6**
	Others			**11**
	Male			**3**
	Female			**8**

Overlapped individuals were counted once across trainings

Annex III: Implementing Agencies of FHI360/USAID CAP-TB Program Organizational Capacity Assessment – Burma

A. Background on CAP-TB Capacity Development

The "Control and Prevention-TB" project, or CAP-TB, aims to decrease the incidence and mortality of MDR-TB in the Greater Mekong Sub-region. Capacity development of local implementing agencies partnered with CAP-TB in Burma, China, and Thailand is one of the project's key priorities with the goal to enable local partners to effectively manage direct funding from USAID.

In Q1 of FY13, FHI 360 began using the Organizational Capacity Assessment Tool (OCAT) to systematically assess the strengths and weaknesses of each implementing agency, creating baseline data to monitor capacity development over time. The OCAT provides a framework for an efficient system to develop capacity by setting the baseline for key capacity areas using a scoring system applied through self-assessment. This is followed by development of an action plan to improve the scores. The self-assessment tool and scores essentially provide a numerical indicator to enable quick assessment of an organization's capacity and its success in developing capacity over time.

FY 13 Quarter 1 and 2 update

During this reporting period, in Myanmar, the CAP-TB Capacity Development Consultant has conducted Organizational Capacity Assessments with the following partner organizations:

- Myanmar Medical Association (MMA)
- Myanmar Health Assistants Association (MHAA)
- Pyi Gyi Khin (PGK)
- Myanmar Business Coalition on AIDS (MBCA)

Preparation and pre-assessment: The CAP-TB consultant introduced the package of OCAT tools to the Burma implementing partners, discussed the process, formed functional area teams and set a timeline for assessment.

Assessment and validation: The CAP-TB team guided the four implementing partners through each step of the OCAT as they assessed seven key capacity areas and developed plans to increase their capacity to manage programs, deliver quality services and lead them towards greater sustainability. Specific action plans have been developed and tailored capacity development assistance will be provided to the partners in the upcoming quarters.

Although specific capacity development plans for each partner will depend on the resources and time available, activities currently anticipated in FY13 and FY14 for Myanmar are presented in the attachment of the work plan. These activities will be revised if needed in collaboration with the partners and USAID RDMA.

B. Organizational Capacity Assessment Tool (OCAT)

In order to track progress and maintain a results-focused approach, the CAP-TB team has adapted several commonly used USAID capacity building indicators to measure the performance of our organizational capacity development (OCD) work. The goal of these OCD indicators is to measure progress toward local capacity development.

As a way to keep track of the number of individuals within partner organizations that have benefitted from the project resources, the number of individuals who have received training, mentoring and any other support, by key capacity areas (below) will be counted. The capacity development effort will be geared towards sustainability of local partners, strengthening both the organizational systems as well as the human resources. The key capacity areas will depend on the results of the baseline assessments and

issues identified by the implementing partners. Project resources to build capacity as well as the commitment from the partners themselves will impact the degree to which the key capacity areas are strengthened.

1. Governance, Vision and Mission
2. Administration
3. Human resources management
4. Financial management
5. Organizational management/Program management
6. Project performance management
7. External Communications

A key measure of the capacity development of each partner is its movement along the following levels in the chosen capacity areas as applicable. In terms of all the CD TA recipients of CAP-TB program as a whole, the percentage of partners demonstrating similar movement along the respective capacity areas can also be tracked. :

Level 1: Beginning
At this level, organizations are just beginning work in the said capacity area.

Level 2: Developing
At this level, organizations show some signs of development within the capacity area, but still need considerable inputs and support.

Level 3: Developed
Partner organizations show results, and need less of supportive intervention. However, results are not always consistent.

Level 4: Model
Partner organizations have achieved their capacity development goals. No more intervention is needed at the current time.

C. Organizational Capacity Assessment of the Myanmar Implementing Agencies

OCAT was introduced to the Myanmar implementing partners between 8 and 11 January, 2013. During the course of the four days, the FHI360 CD team facilitated OCA sessions with a total of 4 IAs in two consecutive batches. The sessions explored partners' existing capacity in key areas as well as the need for strengthening the CAP-TB project and to achieve long term program sustainability objectives. A lot of emphasis was given in gaining mutual trust so that honest discussions could be had in sensitive areas of capacity needs.

Myanmar Medical Association (MMA)
The MMA team OCA was held on January 10 and 11, 2012. The participating team members felt that the association was fairly strong in a lot of areas and enjoyed strong support from its members and counterparts. Participants gave model scores to the board members when it comes to providing strategic vision and insights.

While they lauded the democratic leadership at the MMA, they felt the need for the association to strengthen the participation of its grassroots staff and stakeholders in decision making processes. They also felt that the MMA needed to involve wider stakeholders in setting the vision of the association. Administrative systems scored fairly well and there were only a few areas in which the participating

team members felt that the MMA needed to strengthen its human resources systems and functions. In particular, they sought to provide a system for supporting staff members post their annual performance reviews for further development and growth.

The OCA also highlighted the need for the MMA to involve wider beneficiaries in needs assessments, program planning and program evaluation activities. Financial systems scored quite well, with a few comments indicating that timeliness of monthly reports could improve. External communication emerged as an area in which a lot could be done as it would strengthen the MMA in the long run.

In terms of the overall improvement, the team felt that the MMA needed to do improve bottom up participation in planning and decision making. There was a need to improve performance appraisal system specifically the provision to provide support for improvement. The OCA brought to the fore the need to collect feedback from beneficiaries regularly and the need for the MMA to have a specific communication plan.

Myanmar Health Assistants Association (MHAA)

Developed with a vision that health assistants need to unite to strengthen the force of strive for communities to have a better access to coordinated, effective and comprehensive health care services, MHAA is a professional organization of health assistants initiated in 1954.

MHAA is a professional organization not affiliated with any religion and not involved in political activities. It aims to improve the health of disadvantaged communities by preventing and controlling incidence of communicable diseases and by networking with stakeholders involved in health and related programs.

OCAT was introduced to the MHAA team on 8 and 9 January 2013. During the course of the two days, the FHI360 CD team facilitated sessions to better understand MHAA's existing capacities in key areas as well as the need for capacity development through the CAP-TB resources so that the association could achieve its long term goals and objectives sustainably.

The OCA findings for MHAA showcase the association to have a strong central leadership, with the project management unit that provides the overall policy direction. There is a central executive committee with 21 members, under who rest the supervisory committee followed by the president. In noting the existing communication gap between the project management unit and field operations, the OCA participants called for a written strategic plan a part of which would be communication.

Because most of the projects implemented by MHAA are short term and not resourced enough, participants mentioned that they did not have adequate number of staff, for example, none in the human resources function. Despite this adversity, the association is able to provide constructive services to external stakeholders and staff within the organization. MHAA have felt the need to strengthen its M&E abilities so that information can be generated for making improvements to its programs and they do not have an organizational work plan. They also expressed the need to strengthen the organization's communication abilities.

Myanmar Business Coalition on AIDS (MBCA)

MBCA's vision is that of a better society through socially responsible private sector coalitions and it aims to bring significant changes to people's lives through innovative, sustainable and reliable solutions utilizing simple and effective concepts based on humanitarian spirit of the private sector. MBCA have a standardized operating procedure in several core areas of operation including in its administrative

systems. Board of Directors meeting is held at least once a year and there are quarterly staff coordination meetings. There is a procurement policy and MBCA keeps proper inventory of all project related purchases. Financial and accounting systems at MBCA also follow a SOP and daily cash records are updated in all of its offices.
There is physical checking of cash in cooperation with an official from administration department at the end of every month. A review of MBCA documentation found that the organization keeps record of telephone, email communications and business calls and maintains a system for backing up all computerized data with appropriate antivirus software in every office computer.

MBCA's board members are all expatriates and only one of them is resident in Yangon. The organization is registered under Ministry of Health. The organization has a strategic plan but there is no monitoring of the efforts being made to reach the milestones set. Even though Human Resources is systematic, there are aspects within HR that need further strengthening, such as making performance feedback more supportive. In terms of organizational and program management, MBCA lacks proper indicators to measure and monitor their progress even though they have a good system to follow an annualized work plan. Key staffs also receive training and capacity development support in program planning, budgeting and reporting.

Pyi Gyi Khin (PGK)
Pyi Gyi Khin is a women's organization founded in 1997 with the mission of building capacity of community based organizations, self help groups and volunteers through training, networking and establishing funds to provide basic education and health services and support. PGK has implemented community based HIV/AIDS prevention, care and support projects with technical and financial assistance of various donor agencies including ART management and opportunistic infections (OI) treatment for PLHAs. As a partner of USAID/FHI360 supported CAP-TB program, PGK took part in the OCA assessment on Jan 8 and 9, 2013.

There are a total of 15 members in the executive committee; out of which 2 members are supporting overall organizational management and 3 members are supporting specific programs and projects. One member of PGK executive committee is also a member of the CCM in the country. As the other IAs, PGK feel that they do not have adequate human resources for conducting all operational activities such as administrative, human resources, and finance. Because of the nature of donor funded programs, training and capacity development opportunities have mostly been limited to the specific project staff. PGK do not have core funds for programming and depend on funding received from donor organizations. Their systems are being built gradually and for large scale procurement they rely on the systems of donors.

Monitoring and evaluation is linked with budget and PGK does not have an independent M&E plan other than project specific requirements. The organization aims to generate enough funds in the future for paying for its own programs and activities. OCA participants expressed the need to review PGK's HR policy to make it compliant with the national labor law as well as to review and revamp the organization's M&E systems. In addition, the participants wanted to move away from the quantitative focus of donor funded projects to simply fulfill the number targets and to track progress, identify problems, as well as propose solutions in the programs implemented. PGK staff who attended the OCA also desired to develop a communication plan and improve their website as well as train core staff in effective communication.

D. Prioritizing Capacity Development Areas
As presented in the previous section, each participating management and staff member of all 4 Implementing Agencies in Myanmar gave their own scores to the specific benchmarks within the 7

capacity areas. This produced a ranking of the most important areas along with the ranking of the specific benchmarks within each area. Since CAP-TB program has specific priorities to address for Capacity Development, FHI360 facilitator encouraged the team members to reflect on those priorities along with the long term priorities of the organizations. As per the importance given on building sustainable local systems by USAID Forward, the consultant worked with the teams to develop a clear focus and consensus on three chosen areas for CD. Three areas were chosen for in-depth capacity development as per the organization's own assessment of what was needed the most leading to further direct funding by donors. Even though the team worked to develop consensus on these three areas, in the end each person cast their votes resulting in the following three areas being selected for priority CD in FY 13 and FY 14.

MMA: Selection of top 3 areas for Capacity Development

Every participating member was given an assessment form during the OCA meeting. The summary profile of the assessment form is presented in **Annex I**. Out of 4 possible scores ranging from 1-4, they each gave their preferred scoring to each benchmark within the 7 capacity areas. An average of the scored was tallied as presented in the following table. Following the scoring, FHI360 team led a process of discussion and consensus building for agreeing on what the final three areas for capacity development would be. Participants tried to convince each other, often by using details from their everyday work experience and backed by data/evidence. In the end, there was voting. Detailed votes can be seen in **Table 2**. However, the results of the voting only reversed the order of the top 3 priorities, which are all planned to be addressed.

Table 1: Scores and ranking for prioritizing CD areas

Capacity Area & Scores	AREA 1 Vision/Mission Governance	AREA 2 Admin	AREA 3 HR	AREA 4 Finance	AREA 5 Org Mg	AREA 6 Proj Mg	AREA 7 Ext Com
	3.8	3.7	3.6	3.9	3.9	4.0	3.4
Priority ranking based on scoring	4	3	2	5	6	7	1
Priority ranking based on voting		**3**	**2**				**1**

During the process of voting for the priorities, the team deliberated on each of the benchmarks presented within the OCAT and ranked them in the order of priority as well. These priorities were critical in formulating the results based work plan with clear milestones for the Capacity Development TA. These benchmarks are presented as targeted indicators for FHI360's capacity development work with MMA in the CD work plan for FY13 and FY 14 in **Annex VI.**

MMA Priority Areas and Benchmarks

External Communication

The Myanmar Medical Association ranked external communication highly for capacity development in order to communicate effectively with donors to inform them regarding programs being implemented and to generate support. Additionally, the MMA team indicated that they wanted to develop capacity to communicate with primary target audience (GPs, Specialists members) to inform them regarding programs and seek their increased involvement for broadening its membership base. MMA also ranked external communication highly to communicate with their target audiences from the community to raise demand and improve utilization of MMA services. Following are some of the activities they wish to implement between the third quarter of FY13 and mid of FY14.

- Organizing a participatory workshop to develop MMA's communication plan

- Hire a resource person/technical expert to lead the process of communication plan and external communication development
- Revise and improve/strengthen MMA's existing communication materials
- Communicate effectively with primary target audience (GPs, specialist members) by better mobilizing MMA website and email and through updated brochures/newsletter
- Develop and disseminate/broadcast edutainment programs on TB and MDR TB for raising community awareness.

Human Resources Management

The MMA team at the OCA meeting highlighted the key importance that HR plays in the organization. This area scored 3.6 out of 4 and was selected as a priority for further strengthening. To be followed through within FY14 Q1 by the project manager and the project management team at MMA, the following benchmarks were selected for further development into work plan and deliverables.

- To provide feedback and support to every employee for performance improvement following the results of bi-annual performance appraisal
- To strengthen human resource management for better and efficient performance
- To provide feedback and support to every employee following biannual performance improvement
- To hire the services of a technical expert for developing/updating proper job descriptions for key MMA project staff

Administration

Administration systems strengthening emerged as the third priority for capacity development during the OCA of MMA. Addressing the sixth benchmark within administrative strengthening, the MMA team wanted to involve beneficiaries in needs assessments, program planning, implementation of activities and program evaluation. Specifically, the team felt that MMA could garner stronger participation from its beneficiaries by taking the following simple measures and involving the wider community.

Develop and effectively use community feedback mechanism by placing suggestion boxes targeting different beneficiaries at appropriate places (GPs, Clinics, Village Head house etc.)

Get expert services for periodic analysis of the feedback received from community

Conduct FGDs and two way health talks at the community

Use the results from the analysis of community feedback, FGD and the 2 way health talk for planning future programs and implementing current projects.

Table 2: MMA Detailed voting for prioritizing CD areas:

Details of Individual Votes on Priority CD areas								
SNo	Name	Area 1: Governance Vision and Mission	Area 2: Administration	Area 3: Human Resources	Area 4: Financial Management	Area 5: Organization/Program Management	Area 6: Project Performance Management	Area 7: External Communication
1	Dr. KSW	4	5	2	6	7	1	3
2	MMT	4	3	2	6	5	7	1
3	Dr.KL	5	2	3	6	4	7	1

	T							
			Third Priority	Second Priority				First Priority

MHAA: Selection of top 3 areas for Capacity Development

MHAA OCA participants were all given assessment forms during the OCA meeting. The summary of the scores given by the participating team is included with this report in **Annex I.** Out of 4 possible scores ranging from 1-4, participants each gave their preferred scoring to each benchmark within the 7 capacity areas. The average of the scores is presented in the Table 3 below. During the OCA process, there was a lot of emphasis on consensus building and understanding of the rationale of why certain members scored benchmarks in one way or another. Following the scoring and the team discussions, the team members all voted. Details of the votes are presented in **Table 4**, following **Table 3** below.

Table 3: Scores and ranking for prioritizing CD areas

Capacity Area & Scores	**AREA 1 Vision/Mission Governance**	**AREA 2 Admin**	**AREA 3 HR**	**AREA 4 Finance**	**AREA 5 Org Mg**	**AREA 6 Proj Mg**	**AREA 7 Ext Com**
	3	3.7	3.4	3.8	3.4	3.2	2
Priority ranking based on scoring	2	6	5	7	4	3	1
Priority ranking based on voting			**3**		**2**		**1**

Within the top three priority areas for capacity development presented below, FHI360 TA encouraged the MHAA team to further prioritize a number of benchmarks so that clear action-steps could be taken to implement capacity development work plan achieving results. These benchmarks are presented as targeted indicators for FHI360's capacity development work with MHAA in the CD work plan for FY13 and FY 14 in **Annex VII.**

MHAA Priority Areas and Benchmarks

External Communication

External Communication emerged as the number one priority for the MHAA CAP-TB team. Of the 5 benchmarks contained within EC, the team decided to focus on the following activities for the detailed CD work plan in mobilizing FHI360 CD assistance going forward. The responsible entities will be the Central Executive Committee along with the responsible Admin/Finance focal persons and the Project Manager. Estimated timeframe for all these activities will be between FY13 Q3 until FY 14 Q3.

- Adaptation/Development and effective use of good communications materials (e.g., website, brochure, newsletter, other print materials) to increase awareness of organization overall and CAP-TB related work specifically.
- Staff provided with adequate training/coaching on knowledge and communications skills needed to explain and promote CAP-TB work externally.
- Development of a communication plan and its effective use
- Development and regular updating of a MHAA website and retention of TA to aid in this effort
- Relevant information shared regularly with target audiences through various channels including a quarterly newsletter that will be published and disseminated

Organizational/Program Management

Organization/Program Management got selected as the second area of priority capacity development for MHAA. One of the major activities to be undertaken was the development and use of an organization-wide work plan with an M&E plan to go along with it. Together, these would be used as management tools to strengthen MHAA's program implementation capability and to help the organization improve both receiving of community feedback as well as its use.

To be led by the CEC at MHAA with FHI360's support, the team hope to being the following activities by Q3 of FY13 and implement them until Q3 of FY14.

- With the help of FHI 360 TA, review work plan and M&E plans of similar organizations
- Develop draft organizational work plan and an M&E plan
- Feedback and inputs from staff received on the work plan and M&E plan
- Work plan and M&E plan finalized
- Staff oriented/coached on their effective use for program management
- Begin regular use of work plan and M&E plan as management tools
- Community feedback mechanism of the M&E plan implemented
- Use of information from monitoring and evaluation activities in making adjustments and improvements to programs

Human Resources

Human Resources emerged as the third selected priority for further strengthening at the MHAA OCA. The participants made their choice deliberately as strong HR systems result in strong organizations. The prime motivation of improving HR systems was to provide the needed help and support to staff members in fulfilling project/program objectives. The following are some of the activities that MHAA intends to carry out with FHI360 TA support.

- To assess the current methods of conducting performance assessment of staff members
- Existing methods, forms and checklist for performance evaluation reviewed and revised
- New method of performance assessment implemented annually, one that provides ongoing support and opportunity for further development
- By utilizing performance evaluation as a point of encouraging and capacitating staff, MHAA plans to provide training/mentoring/coaching to support further capacity development
- Training provided to staff on organization development, financial management, leadership development, report writing etc. as needed by staff

Table 4: Detailed voting for prioritizing CD areas:

Details of Individual Votes on Priority CD areas								
SNo	Name	Area 1: Governance Vision and Mission	Area 2: Administration	Area 3: Human Resources	Area 4: Financial Management	Area 5: Organization/Program Management	Area 6: Project Performance Management	Area 7: External Communication
1	AK	4	6	5	7	3	2	1
2	TO	2	6	3	7	4	5	1

3	NN	3	6	4	5	2	6	1
				Third Priority		Second Priority		First Priority

MBCA: Selection of top 3 areas for Capacity Development

Every participating member was given an assessment form during the OCA meeting. The summary profile of the assessment form is presented in **Annex I**. Out of 4 possible scores ranging from 1-4, they each gave their preferred scoring to each benchmark within the 7 capacity areas. An average of the scored was tallied as presented in the following table. Following the scoring, FHI360 team led a process of discussion and consensus building for agreeing on what the final three areas for capacity development would be. Participants tried to convince each other, often by using details from their everyday work experience and backed by data/evidence. In the end, there was voting. Detailed votes can be seen in **Table 6** following **Table 5** below which has the scores and ranking. However, the results of the voting only reversed the order of the top 3 priorities, which are all planned to be addressed.

Table 5: Scores and ranking for prioritizing CD areas (MBCA)

Capacity Area & Scores	AREA 1 Vision/Mission Governance	AREA 2 Admin	AREA 3 HR	AREA 4 Finance	AREA 5 Org Mg	AREA 6 Proj Mg	AREA 7 Ext Com
	3.4	3.5	3.3	3.6	2.8	3.2	2.4
Priority ranking based on scoring	5	6	4	7	2	3	1
Priority ranking based on voting			**3**		**2**		**1**

During the process of voting for the priorities, the team deliberated on each of the benchmarks presented within the OCAT and ranked them in the order of priority as well. These priorities were critical in formulating the results based work plan with clear milestones for the Capacity Development TA. These benchmarks are presented as targeted indicators for FHI360's capacity development work with MBCA in the CD work plan for FY13 and FY 14 in **Annex VIII.**

MBCA Priority Areas and Benchmarks

External Communication

In order to make the wider community aware of the work that MBCA carries out, external communication emerged as the top priority for the coalition. The OCA participants hoped that strengthened EC will lead to familiarity of its activities and provide better access to community and donors. The following are some of the envisaged activities for FY 13 and FY 14 to be focal pointed by the senior management team and MBCA communication officer along with FHI360 TA.

- Review of communication plans of other organizations leading to the adaptation and development of good communications materials (e.g., website, brochure, newsletter, other print materials) to increase awareness of organization overall and CAP-TB related work specifically.
- Development and finalization of a communication plan
- Staff provided with adequate training/coaching on knowledge and communications skills needed to explain and promote CAP-TB work externally.
- Relevant information shared regularly with target audiences, in particular by enhancing existing broadcasting of news from radio and reaching out the TV stations.

- Arrange for the reporters of journals to conduct interviews of MBCA stakeholders and beneficiaries

Organizational/Program Management

During the OCA discussions, the MBCA participants spoke about the need for the organization to strengthen program management. In particular, they wanted to develop and use organizational work plan and M&E plan as effective management tools. They also wanted key MBCA staff and personnel to be trained in effective program management. The following are some of the activities the team envisioned to carry out in FY 13 and FY14 with the support of the executive director, the director of programs, project manager as well as the assistant/project officer.

- Review of work plan and M&E plan of various projects within MBCA, as well as through TA look at effective use of work plan and M&E plan for program management
- Development of first draft of Organizational work plan and M&E plan
- Finalization of MBCA's organizational work plan and M&E plan
- Orientation of staff in using work plan and M&E plan as tracking tools for effective implementation.
- Regular use of the work plan and M&E plan
- Staff trained for effective program management

Human Resources

The MBCA team at the OCA meeting highlighted the key importance that HR plays in any organization and ultimately selected it as a priority are for further strengthening. Several benchmarks were selected for further development so as to improve the employee assessment procedures; to utilize time sheet regularly; and to improve efficiency in program management. The responsible persons to take this forward are the HR officer of MBCA, the program officer of CAP-TB program and the project manager. Between Q2 of FY13 and Q3 of FY14, the following activities are to be conducted.

- Annual application of 360 degree performance appraisal following which feedback and support will be given to staff
- TA on timesheet improvement and adoption of the new time sheet recording and tracking system
- Staff trained for improving efficiency in program performance

Table 6: Detailed voting for prioritizing CD areas: (MBCA)

Details of Individual Votes on Priority CD areas								
SNo	Name	Area 1: Governance Vision and Mission	Area 2: Administration	Area 3: Human Resources	Area 4: Financial Management	Area 5: Organization/Program Management	Area 6: Project Performance Management	Area 7: External Communication
1	NNO	5	7	3	4	2	6	1
2	TDK	5	4	6	7	2	3	1
3	AHL	6	5	4	7	2	3	1
				Third Priority		Second Priority		First Priority

PGK: Selection of top 3 areas for Capacity Development

Every participating member was given an assessment form during the OCA meeting. The summary profile of the assessment form is presented in **Annex I**. Out of 4 possible scores ranging from 1-4, they each gave their preferred scoring to each benchmark within the 7 capacity areas. An average of the scored was tallied as presented in the following table. Following the scoring, FHI360 team led a process of discussion and consensus building for agreeing on what the final three areas for capacity development would be. Participants tried to convince each other, often by using details from their everyday work experience and backed by data/evidence. In the end, there was voting. Detailed votes can be seen in **Table 8**. However, the results of the voting only reversed the order of the top 3 priorities, which are all planned to be addressed.

Table 7: Scores and ranking for prioritizing CD areas of PGK

Capacity Area & Scores	AREA 1 Vision/Mission Governance	AREA 2 Admin	AREA 3 HR	AREA 4 Finance	AREA 5 Org Mg	AREA 6 Proj Mg	AREA 7 Ext Com
	2.6	2.8	2.4	3.1	2.5	2.8	2.2
Priority ranking based on scoring	4	5	2	7	3	6	1
Priority ranking based on voting			**2**		**3**		**1**

During the process of voting for the priorities, the team deliberated on each of the benchmarks presented within the OCAT and ranked them in the order of priority as well. These priorities were critical in formulating the results based work plan with clear milestones for the Capacity Development TA. These benchmarks are presented as targeted indicators for FHI360's capacity development work with PGK in the CD work plan for FY13 and FY 14 in **Annex IX.**

PGK Priority Areas and Benchmarks

External Communication

External Communication emerged as the number one priority for the PGK CAP-TB team. The OCA participants deliberated on various activities that could be carried out in order to give required information to donors, stakeholders and beneficiaries about activities and future plans of PGK. Evident in the team discussions was the desire to have all PGK colleagues gain the needed capacity in communication skills for them to explain and promote PGK externally. To be spearheaded by the program coordinator with the support of the executive committee and senior management team, the following activities are to be implemented between Q3 FY13 and Q2 FY 14.

- Train staff on knowledge of external communication and developing communication materials
- Adaptation and development of communications materials (e.g., website, brochure, etc.) to increase awareness of organization overall and CAP-TB related work specifically.
- Setting timeline for external communication strategy including press kit
- Orientation of PGK staff on external communication
- Staff coached on knowledge and communications skills needed to explain and promote CAP-TB work externally.
- Relevant information shared regularly with target audiences.
- Periodic updating the existing communication materials

Organizational/Program Management

During their organizational capacity assessment, the PGK team discussed at length about the need to strengthen results based management. They aimed to strengthen results based M&E system and use information generated for making adjustments so as to improve program performance using regular feedback from stakeholders. There were discussions on sustainability and the team's desire to potentially access USAID and other donor support by further strengthening organizational transparency and engagement with beneficiaries. The following are the activities that are to be carried out by FY14 Q4 to strengthen M&E.

- Staff receive updated training on M&E including on relevant software usage
- Develop/revise/update and implement a user friendly project database system (forms, analysis, utilization of feedback in decision making etc.)
- Review and update existing M&E manual
- Staff trained in M&E share relevant M&E knowledge with other staff by providing updates on M&E including on relevant M&E software

Human Resources

- Human Resources emerged as a key priority for strengthening the PGK. The team at the OCA meeting selected several key benchmarks to strengthen Human Resources Management and further develop the PGK HR System. In terms of the timing, they hope to being implementing these improvement measures with the help of FHI360 TA by the second quarter of FY13. The following are several key activities to be implemented.
- Human Resource Policy revised and made compliant with the national labor laws as well as implemented/applied
- Sufficient numbers of staff are recruited according to project needs
- Staff receives appropriate training and coaching
- Constructive feedback is given according to performance appraisal
- HR policy is revised and made compliant with the national labor laws
- Provide staff with appropriate training and coaching on knowledge and skills they need for performance of their work
- Senior staff coached/mentored on providing constructive feedback and adequate support mechanism following staff appraisals

Table 8: PGK Detailed voting for prioritizing CD areas:

Details of Individual Votes on Priority CD areas								
SNo	Name	Area 1: Governance Vision and Mission	Area 2: Administration	Area 3: Human Resources	Area 4: Financial Management	Area 5: Organization/Program Management	Area 6: Project Performance Management	Area 7: External Communication
1	Dr.NT	2	4	3	6	5	7	1
2	EEP	4	6	2	5	3	7	1
3	THO	6	4	2	7	5	3	1
4	KW	1	7	3	6	2	5	4
				Second Priority		Third Priority		First Priority

E. MMA, MHAA, MBCA and PGK Plan of Action for Organizational Capacity Development

All 4 organizations developed detailed plans for addressing the capacity needs mobilizing FHI360 TA for capacity development. Refer to **Annex VI-IX** for the **work plan**. The Annexes list details regarding planned activities, measurement benchmarks, timeline and responsible persons for taking forward the CD work plan.

CHINA

Period covered: 1st October 2012 to 30th March 2013

Acronyms

AIDS	Acquired immune-deficiency syndrome
BCC	Behavioral Change Communication
CAA	Chinese Antituberculosis Association
CAP-TB	Control and Prevention of Tuberculosis (Greater Mekong Sub-region Multidrug-Resistant Tuberculosis Prevention and Management Project)
CBO	Community-based organization
CDC	Center for Disease Control and Prevention
CHC	Community health center
DOT	Directly-observed treatment
DR	Drug resistant
DQA	Data Quality Assessment
EQA	External Quality Assessment
F&A	Finance and Administrative
FHI 360	Family Health International 360
FY	Fiscal year
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus
IC	Infection Control
IEC	Information, Education, and Communication
IR	Intermediate Result
M&E	Monitoring and evaluation
MDR-TB	Multidrug resistant tuberculosis
MTB	Mycobacterium tuberculosis
NA	Not Available
NCTB	Chinese National Center for Tuberculosis Control and Prevention
NTP	National Tuberculosis Control Program
OCA	Organizational Capacity Assessment
PLHIV	Person (People) living with HIV/AIDS
PMDT	Programmatic Management of Drug-Resistant Tuberculosis
PPP	Private-public partnership
PTB	Pulmonary tuberculosis
Q	Quarter
RD	Residential District (*jie dao* 街道)
SFDA	Chinese State Food and Drug Administration
SOP	Standard operating procedures
TA	Technical Assistance
TB	Tuberculosis
YATA	Yunnan Anti-Tuberculosis Association
Yunnan TCC	Yunnan Tuberculosis Clinical Center
The Union	The International Union Against Tuberculosis and Lung Disease
USAID	United States Agency for International Development

Narrative I: Executive Summary

The following report details Family Health International (FHI) 360's progress in implementing the Control and Prevention of Tuberculosis (CAP-TB) project during the first two quarters of fiscal year 2013 (FY13; October 2012 through March 2013 inclusive) in Kunming, Yunnan Province (China), as part of the United States Agency for International Development's (USAID) Greater Mekong Sub-region Multidrug resistant tuberculosis (MDR-TB) Prevention and Management Project. Descriptions of progress are organized according to the CAP-TB FY13 China Work Plan. In instances where multiple activities took place under a single category, individual activities are further separated by un-numbered subheadings, arranged chronologically or by administrative level (highest to lowest). Last names have been capitalized for clarity.

It should be noted that the most important celebration in China, Spring Festival (i.e., Chinese Lunar New Year), takes place over the course of at least two weeks of Quarter Two (Q2). This year, the first day of Spring Festival was February 10. The five days of public holiday interfere with regular program activities; in addition, use of public services (including healthcare services) drops off significantly before and after the festival as many TB patients travel back home, in what some media organizations have called the largest annual human migration in the world.[1]

Narrative II: Program Performance during FY13 Q1 & Q2

Program performance during FY13 Q1 and Q2 is discussed below, following the activities outlined in the China Work Plan.

Program Management

In January, FHI 360 Kunming welcomed two new staff members: Mr. XU Zhixiang (Program Officer) is responsible for the organization, implementation, coordination, and supervision of CAP-TB project activities; Ms. CHEN Jing (Administrative and Finance Officer) is responsible for providing general assistance, including administrative and financial documentation support, procurement, and travel arrangements.

Finance and Administrative Review: From January 29 to February 1, Ms. WANG Qi (consultant) provided a three-day, on-site training for Ms. CHEN Jing (FHI 360 Kunming) focused on finance and administrative (F&A) policy. On January 30, they conducted financial monitoring for the Yunnan Anti-Tuberculosis Association (YATA) using the F&A review checklist. Ms. WANG submitted an F&A review report, which highlighted several issues, such as the lack of a "PAID" stamp on some payment vouchers, no hotel folio for the training held in Guangxi (one case), and no details of purchasing meeting materials. Upon submission of Ms. WANG's report, a meeting was held between FHI 360 and YATA to address the issues raised in the report, and YATA has fully rectified these issues.

Organizational Capacity Assessment: From January 30 to February 1, Mr. Siddhi ARYAL (consultant) and FHI 360 Kunming office staff (Ms. LI Ling and Mr. XU Zhixiang) conducted an organizational capacity assessment (OCA) for YATA. A total of 15 people participated in the assessment. Using the OCA tool, YATA members identified three areas that required improvement: 1) external communication, 2) human resource management, and 3) administration. Participants developed an action plan to address these weaknesses; this plan included designed activities, measurement benchmarks, and a timeline, and also delegated responsibilities to individuals to carry forward the capacity development. FHI 360 will work with YATA to further improve current organizational capacity.

Intermediate Results

Progress is presented for four intermediate results (IR):

[1] http://news.bbc.co.uk/2/hi/asia-pacific/7813267.stm

1) Strengthened MDR-TB prevention;
2) Strengthened MDR-TB management;
3) Improved strategic information for MDR-TB; and
4) Strengthened enabling environment for MDR-TB control and prevention.

IR 1: Strengthened MDR-TB Prevention

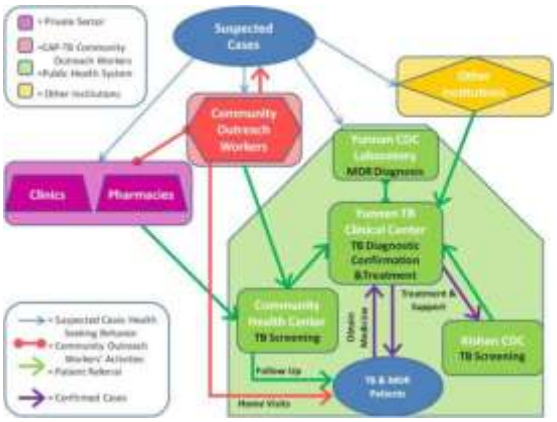
FHI 360 recognizes that successful control of MDR-TB requires preventing the emergence of new cases of both drug-susceptible and drug-resistant TB. Prevention is thus a key component of the CAP-TB model in China, as well as a founding pillar of the Chinese healthcare system, exemplified by the motto located at the entrance of the Yunnan Center for Disease Control and Prevention (CDC): "Prevention is the key" (*yufang wei zhu*预防为主).

Output 1.1: Mobilized communities to advocate for and use of TB services

Activity 1.1.1: Develop CAP-TB strategic model for strengthening MDR-TB prevention in communities

All CAP-TB partners worked together in FY12 to develop the CAP-TB strategic model. During this reporting period, FHI 360 staff worked to strengthen and implement the CAP-TB strategic model, most notably through regular meetings of the CAP-TB Working Group (see IR 3.1.2). In order to increase TB services uptake by community members, in March 2013 FHI 360 signed an agreement with the Xishan District Women's Federation to expand community outreach to three new high-prevalence residential districts (Haikou, Majie, and Yongchang) in addition to the existing project catchment areas of Fuhai and Zongshuying residential districts (see IR 1.1.6).

In order to further strengthen the CAP-TB strategic model, FHI 360 produced a patient flow chart to clearly delineate the roles and responsibilities of the different partners, as well as the proper referral pathways from screening through TB treatment and follow-up care.



Activity 1.1.2: Conduct community education

Mapping Activity: In November 2012, community outreach workers and Xishan CDC staff conducted a mapping exercise in Fuhai and Zongshuying, the two residential districts (RDs) originally targeted under the CAP-TB project. The exercise identified private healthcare providers (e.g., private clinics, pharmacies), public health institutions (e.g., health care stations, community health centers), and community gathering spots (e.g., fresh food markets, mahjong parlors, parks), and guides community outreach workers' activities. Given rapid development in the catchment area, outreach workers will update maps quarterly. By the end of March 2013, there are 111 private-sector partners (79 private clinics and 32 pharmacies) working with the national TB control program with USAID support (USAID PMP Indicator 24)

Venue/Location		Zongshuying RD	Fuhai RD	Combined
Private Healthcare Providers	Private Clinic	24	55	79
	Pharmacy	12	20	32
Public Spaces	Fresh Food Market	5	6	11
	Mahjong Parlor	7	8	15
	Kindergarten/Primary School	2	13	15
	Street Park	-	7	7
Public Health Institutions	Health Care Station	-	2	2
	Community Health Center	1	1	2

Note: Figures reflected the most recent updates, March 2013.

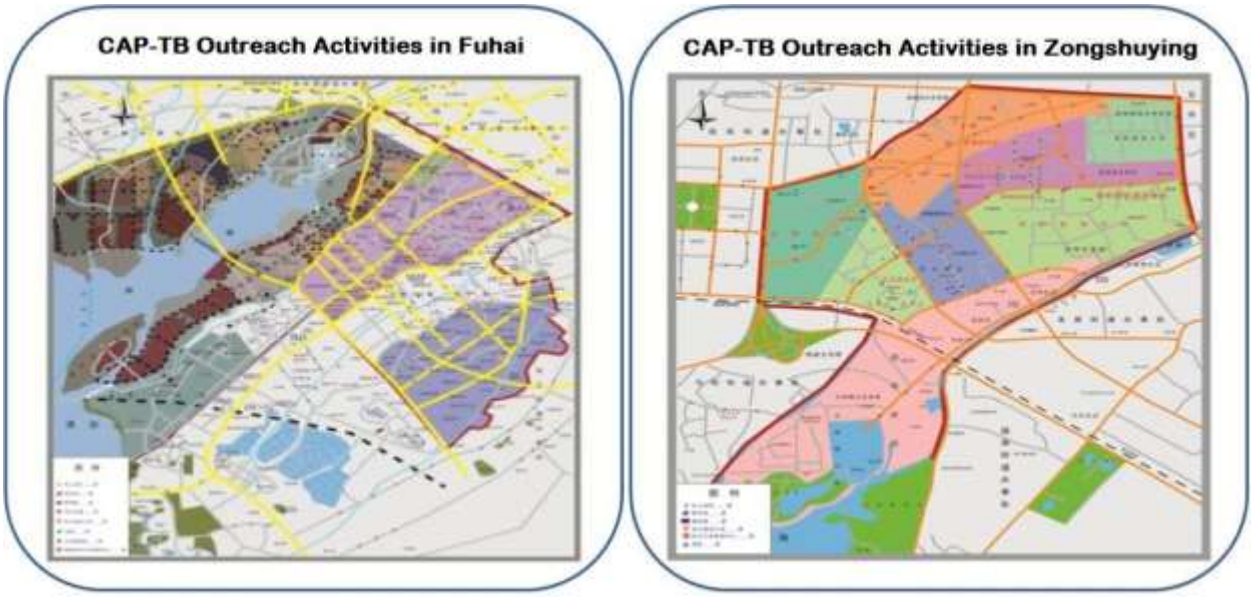


Figure 1. Fuhai and Zongshuying RD Outreach Worker Activities Maps. Maps pinpoint private healthcare providers, public spaces, and public health institutions to more clearly show the distribution of such places in the CAP-TB catchment area, and guide outreach activities.

Daily Educational Activities: Four community outreach workers conduct activities Monday through Friday across Fuhai and Zongshuying RDs to spread awareness about TB symptoms, available services, and the appropriate institutions for diagnosis and treatment. During this reporting period , outreach workers distributed 2,553 pieces of anti-tuberculosis information, education and communication (IEC) materials including tissue packages, maps with TB service locations and TB information pamphlets. Topics discussed included TB prevention, service locations and government treatment policies.

Information, Education, and Communication Activities:

Figure 2. Posters Developed by Kunming CDC. From left to right, the three posters focus on: 1) Airborne TB transmission, 2) the government's free TB testing and treatment policy and the appropriate care sites in Kunming, and 3) common TB symptoms, including cough, bloody sputum, evening fever, and night sweats.

With the assistance of FHI 360 and a design company, the Kunming Municipal CDC designed and pre-tested three posters and one 2013-2014 calendar promoting TB prevention and control. Materials were revised five times before final production and distribution. In Xishan District, 1,500 copies of each poster (i.e., 4,500 total posters) and 3,300 calendars have been distributed, mostly after Spring Festival. These IEC materials were widely used for World TB Day activities (see IR 1.1.7). In addition, 300 copies of large-sized posters were reprinted and displayed at major public places in Xishan District from March to April 2013.

Project staff also distributed tissue packets and paper cups, labeled with TB prevention and treatment messages, which were previously developed by the Yunnan CDC and appropriated for CAP-TB outreach activities.

Figure 3. 2013-2014 Calendars Developed by Kunming CDC (right). Message reads: "To control tuberculosis, early diagnosis and treatment, [and] standardized treatment [are key]; [additionally, maintain a] healthy lifestyle, support is important, prevent drug resistance"

HIV/TB Collaborative Activities: In collaboration with CAP-TB partners, and with Global Fund to Fight AIDS, TB, and Malaria (Global Fund) funding, FHI 360 coordinated China's first capacity strengthening

training for HIV/TB grassroots organizations. Thirty-five participants from 22 HIV community-based organizations (CBOs) across Yunnan participated in the training, held November 19-23, which served as a platform for government TB experts, CAP-TB outreach workers, and HIV CBO staff to share experiences and discuss the next steps for TB prevention and control. Presentations covered the history of anti-TB efforts in China, proper referral, and basic TB, MDR-TB, and HIV knowledge. Participants also visited the Yunnan TCC, where they discussed available TB services with staff.

After the training, CAP-TB staff selected three HIV CBOs to disseminate TB information among their constituents. Selection criteria included willingness to collaborate with CAP-TB and previous health-related work experience (i.e., HIV prevention and TB screening among HIV patients). These CBOs have incorporated TB awareness activities into 31 of their group activities, and referred nine individuals with TB symptoms for screening, one of whom took up the referral.

Outreach Flip-Chart: In order to further support outreach workers, structure interactions with the community, and ensure concise and accurate outreach, FHI 360 developed a community outreach flip-chart tool. The flip-chart contains information to be read by the outreach worker on one side of the page, and a set of key message bullet points to be viewed by the audience on the other. The flip-chart contains information on: 1) basic TB knowledge, 2) a risk assessment evaluation, 3) TB diagnosis and treatment, and 4) government and CAP-TB services. FHI 360 pre-tested the flip-chart among community outreach workers and YATA staff in March and is revising based on feedback, with a final version expected in FY13 Q3.

Xishan District Women's Federation: On March 13, Ms. LI Ling and Mr. XU Zhixiang (FHI 360 Kunming) held a half-day training for the Xishan Women's Federation. A total of 37 people were present, including 30 community outreach workers - women leaders in the community (USAID PMP Indicator 20), two FHI 360 facilitators, three staff of the Xishan District CDC, and two representatives from the Women's Federation who spoke at the event. The training focused on: 1) providing basic tuberculosis knowledge (e.g., mode of transmission and treatment, government free police); 2) introduction to the FHI 360 CAP-TB project and the roles and responsibilities of the Women's Federations under the project; 3) proper referral to appropriate health organizations under the CAP-TB project; and 4) introduction of M&E tools and procedures. Female community outreach workers who participated in the training will conduct community educational activities and promote uptake of TB services in five RDs in Xishan District.

Outreach Team Leader: In March, Ms. LU Xuelian was appointed as community outreach team leader with responsibility for ensuring effective outreach, facilitating the expansion of outreach activities, and monitoring data collection to ensure continued data quality. This new role was made possible through an addendum to the China Work Plan (submitted to APRO for approval on March 12th).

CAP-TB English Corner: Mr. Emilio Dirlikov held a weekly "English Corner" for Yunnan CDC TB workers, which focused on practicing speaking and listening skills, and pronunciation of TB-related terms. In addition, Mr. Dirlikov distributed English-language materials to CAP-TB partners, including his "Chinese-English Glossary of Tuberculosis and Related Terminology" and "Common Writing Mistakes," which he further developed for the Yunnan context. A total of seven sessions were held between January and March 2013, with an average of ten participants per session.

Activity 1.1.3: Provide information to private clinics about MDR-TB

Xishan CDC Guidance: During this reporting period, Xishan CDC provided on-site guidance for private clinics, focusing on the introduction of the CAP-TB project and proper referral practices.

Outreach Activities: As part of their regular activities, community health workers visited private clinics to introduce the CAP-TB project, build trust-worthy relations, and follow-up on proper referral practices.

Activity 1.1.4: Provide information to pharmacies about MDR-TB

Xishan CDC Guidance: During this reporting period, Xishan CDC provided on-site guidance and training for private pharmacies, focusing on the introduction of the CAP-TB Project and proper referral practices.

Pharmacy Training Sessions: Xi Shan CDC and the FHI 360 Kunming office held two training sessions on November 23 to introduce the CAP-TB project, coordinate referrals, and provide information on TB and MDR-TB more generally to pharmacies in the Fuhai and Zongshuying RDs. A total of 110 pharmacies were invited, and 110 people attended (one person per pharmacy).

Outreach Activities: As part of their regular activities, community health worker visited private pharmacies to introduce the CAP-TB project, build trust-worthy relations, and follow-up on proper referral practices.

Activity 1.1.5: Train community health service center staff

As outlined in the China Work Plan, Xishan CDC staff conducted two training sessions during FY13 Q1. Eighteen community health center (CHC) staff participated in human resources training under the CAP-TB project on October25, and 15 members from Fuhai and Zongshuying RDs, including the four community outreach workers, participated in an outreach training on November 9.These trainings focused on refreshing and consolidating knowledge already presented, such as TB treatment, adherence problems, and identifying high-risk groups.

Activity 1.1.6: Conduct community outreach through women's groups

Fuhai and Zongshuying RD Community Outreach Workers: During this reporting period, outreach workers conducted 12 TB patient home visits, five of which occurred in Fuhai RD. Zongshuying RD outreach workers also followed up with three TB patients over the telephone (see also Activity 1.1.2).

Xishan District Women's Federation: In order to strengthen the involvement of existing women's groups in community outreach for TB control and prevention, FHI 360 created an addendum to its work plan to include the Xishan District's Women's Federation as a CAP-TB partner. Under the agreement, community outreach workers will now reach three additional RDs (Haikou, Majie, and Yongchang) as well as the original two RDs (Fuhai and Zongshuying). A half-day training of 30 community outreach workers was held on March 13 (see Activity 1.1.2). Thereafter, Xishan District Women's Federation conducted educational activities in 13 communities of the targeted RDs, and reached 112 people, 68 (60.7%) of whom were women. These community outreach workers participated in World TB Day activities (see Activity 1.1.7).

Activity 1.1.7: Organize activities to commemorate World TB Day

Several partners coordinated activities to commemorate World TB Day:

Yunnan Anti Tuberculosis Association: YATA held an event in Kunming's Guandu historic area on March 22. More than 50 health workers participated in the event, including members of the Yunnan Provincial Health Bureau, the Yunnan CDC, Yunnan Province Preventive Medicine Association, YATA, and Yunnan Guangdian Media Limited. An additional 23 volunteers were recruited from Yunnan Provincial Agricultural University and Kunming Municipal Medical College. At the event, the Yunnan CDC vice-director, DR. YANG Jun, spoke on TB's primary mode of transmission as well as socio-economic factors that are related to the epidemiology of TB in China. He further reported on activities conducted over the past year, under the slogan "Volunteers united towards spreading basic TB prevention and treatment knowledge" ("百千万志愿者结核病防治知识传播行动"). The provincial anti-tuberculosis celebrity

ambassador, Mr. MENG Zhi, delivered a special message about the importance of community involvement in preventing TB and spreading basic knowledge. Singers from Yunnan TV's program "Beautiful Voice" enlivened the event with vocal performances.

Approximately 2,000 people attended, 1,100 (55%) of whom were women. A variety of IEC materials were distributed throughout the event, including 5,300 leaflets, 4,800 tissue paper packets, 2,500 primary school notebooks, 1,180 posters, 1,500 eco-friendly multi-use bags, and 90 t-shirts. A Yunnan CDC expert was on hand to answer questions, and was approached by approximately 30 people who requested more detailed information.

Kunming CDC/Xishan CDC: On March 22, Kunming CDC and Xishan CDC organized activities to commemorate World TB Day, under the slogan: "You and me united towards eliminating the risk of TB" ("你我共同参与、消除结核危害"). Sixty-one workers were mobilized for the successful execution of the activities, which focused on spreading basic knowledge of TB prevention and treatment, introducing special governmental diagnostic and treatment policies and TB treatment guidelines. Ten banners and five movable billboards were set up in a public square to draw attention to the activities. Over 6,000 pieces of IEC materials were distributed, as well as 90 t-shirts. Further, approximately 100 members of the community were provided one-on-one consultations with health workers, where they were able to ask questions on TB as well. FHI 360 staff and community outreach workers helped in the distribution of IEC materials and administered the first round of FY13 TB Trends surveys, which will assess the TB and related health-seeking behaviors, attitudes, and practices of people in the CAP-TB catchment area (see IR 3.2.1).

Xishan District Women's Federation: As part of the World TB Day activities taking place in Xishan District, newly trained community outreach workers distributed IEC materials (see IR 1.1.2), and spoke to members of the community about basic TB knowledge, and how to refer friends and family members to appropriate health organizations for screening.

Output 1.2: Scale-up implementation of TB infection control in communities and health facilities

Activity 1.2.1: Provide training on IC for health providers in Yunnan TCC

In FY12, Dr. JIANG Chenyuan[2] a consultant from the International Union against Tuberculosis and Lung Disease (The Union), hired by FHI 360, identified a number of infection control challenges in the physical lay-out of the Yunnan TCC. The Yunnan Health Bureau committed RMB 100,000 (USD 15, 873) for renovations to decrease the risk of secondary infections. The Health Bureau has subsequently doubled this commitment (to USD 31,746), and Yunnan TCC renovations, which included installing fans in all patient rooms, redistributing the space to keep patients and staff activities more separated, and upgrading showering facilities, were completed in early March 2013.

Dr. JIANG returned in late February 2013 for MDR-TB training and visited Yunnan TCC before they finished these renovations.

Activity 1.2.2: Provide training on IC for patients and families in Yunnan TCC

Since July 2012, project staff have held monthly discussion groups between TB and MDR-TB in-patients, their family members, and Yunnan TCC healthcare providers. From October 2012 to March 2013, 43 individuals have participated in these discussions (27 men, 16 women). Discussion topics have included:

[2] Dr. Jiang's name is also transliterated as "Dr. Chiang Chen-yuan" under the Wade-Giles romanization system, which is used in his native Taiwan.

infection control (e.g., household, personal protection), familial support (e.g., psychological support), and patient adherence (e.g., DOT, potential side-effects). Of note, the December meeting was self-organized by six MDR-TB patients, who wrote a letter to staff of the Yunnan TCC, Global Fund, and CAP-TB project to thank them for their support, and to express their desire for more individualized treatment plans.

Activity 1.2.3: Develop IC guidelines for household and community level

During this reporting period, Yunnan TCC held regular monthly patient and family meetings at which household IC was discussed. In the following quarter, FHI 360 Kunming will receive an IC checklist from APRO and will test this checklist at the Yunnan TCC and in the community. More formal household and community-level IC guidelines will be developed later.

Data Summary for IR1:

Indicator 2 (USAID PMP Indicator 9): Number of individuals reached with TB prevention and treatment messages, through outreach and small group activities.

# Contacts	Contacts by Gender		Contacts by Population Group		Topic Areas Discussed	Remarks
2477	M	1210	Migrants	329	TB signs, symptoms, and treatment Where to go for diagnosis and treatment The importance of treatment adherence	The program was not accurately tracking number of unique individuals reached , or disaggregating by population groups, until an improved M&E form was introduced in March 2013
	F	1267	Diabetics	1		
			Elderly	89		
			General Population	150		
			Other	1908 (including 1,874 reached before population groups were tracked		

Indicator 3: Number of individuals referred to TB- and MDR –TB related services. Report by gender; referral source (outreach, private partner such as pharmacies, private clinics/hospitals, and lower level health care facilities such as health stations/posts; and population group (migrant, prisoner, PLHIV, diabetic, elderly, close contact of TB/MDR-TB case, TB or MDR-TB case, general population or other)

# Contacts	Contacts by Gender		Referrals by Source		Contacts by Population Group
746	M	425	Outreach	29	Not available as the referral cards didn't record information about population groups.
			Pharmacy/ Private clinic	276	
	F	321			
			Lower level health care facilities	441	

IR 2: Strengthen MDR-TB management

From October 2012 to March 2013, 128 cases of PTB (86 men and 42 women) and eight cases of MDR-TB (eight men) were found in Xishan District. From October 2012 to March 2013, the Yunnan TCC detected 19 new PTB cases (17 men and two women), and zero new MDR-TB cases from Xishan District. During the same period, the Yunnan TCC treated 1,226 patients, of whom 647 (52.7%) were women; none of these patients came from CAP-TB projects' five RDs. The Yunnan TCC treated 25 MDR-TB patients, of whom 15 new cases were diagnosed between October 2012 and March 2013. Fifteen confirmed new MDR-TB patients started treatment there and initiated the MDR-TB package (USAID PMP Indicator 10). Three patients dropped out due to the treatment's adverse effects. By the end of the reporting period, no patient had reached six months of treatment on the MDR-TB regimen.

Output 2.1: Ensure capacity availability and quality of laboratory testing to support diagnosis and monitoring of TB patients, including rapid diagnosis of MDR-TB

Activity 2.1.1: Provide training for laboratory staff in new diagnostic tools

The CAP-TB project provided one GeneXpert machine and one LED fluorescent microscope to the Yunnan CDC and Yunnan TCC respectively. Both were delivered in September 2012, and were operational as of October 2012. Laboratory technicians were in continual telephone communication with the GeneXpert technical assistants whenever problems were encountered, and an on-site supervision visit occurred on January 23 GeneXpert tests were administered for patients meeting certain risk criteria (described under Output 2.2). The government covered operational expenses, including the costs of the cartridges.

From October2012 to March 2013, 75 LED samples were tested and 70 samples were assayed with the GeneXpert machine, resulting in the detection of 25 rifampicin-resistant cases, as follows:

Table 1: GeneXpert Tests conducted at the Yunnan CDC, from October 2012 to March 2013[3]

Month	Samples tested	*Mycobacterium tuberculosis* (MTB) complex DNA		MTB not detected	Errors	Invalid Numbers
		Rifampicin Resistant	Rifampicin Sensitive			
October	1	1	0	0	0	0
November	28	7	4	17	0	0
December	34	11	12	7	3	1
January	8	3	5	0	0	0
February	1	0	0	0	1	0
March	3	3	0	0	0	0

Activity 2.1.2: Strengthen capacity of laboratory staff in sputum culture and EQA through training

[3] "Error" and "Invalid" results both denote assays that did not produce proper readings of the sample. GeneXpert may produce an "Error" result if: 1) *Mycobacterium tuberculosis* (MTB) DNA is not detected or there is a failure to read, 2) if the Sample Processing Control (SPC) is not detected or produces no result, or 3) if there is a system component error that does not allow the machine to read the assay. "Error" might also be produced if Probe Check control fails and the assay is aborted (e.g., if the reaction tube is improperly filled through human negligence), a problem with the integrity probe is detected, or if the maximum pressure limits are exceeded. "Invalid" results mainly from failure with the SPC, which happens if the sample was not properly processed or PCR was inhibited. Like with "Error" readings, such failures can cause the machine to not detect MTB DNA, or for the SPC not to be detected or to produce no result. The SPC works with Probe Checks in order to ensure the quality control for GeneXpert. Specifically, SPC allows for samples to be properly processed, by: 1) verifying lysis of the sample's MTB, 2) verifying processing of the specimen, and 3) detecting specimen-associated inhibition of the real-time PCR assay.

From March 27 to 28, Ms. Suwanee SUNGKAWASEE (Senior Laboratory Specialist, FHI 360 Bangkok) conducted a two-day training for laboratory staff. Ten participants from Yunnan CDC, Yunnan TCC, Kunming CDC, and Yunnan AIDS Care Center attended the training. The training covered: TB laboratory diagnostic methods, TB laboratory quality management system, and biosafety. Upon conclusion of the training, Ms. Suwanee met with Yunnan CDC and Yunnan TCC laboratory heads to discuss how FHI 360 could further support the two respective laboratories in obtaining ISO 15189 accreditation.

Output 2.2: Strengthen case finding and referral for MDR-TB

According to Global Fund and the National Tuberculosis Control Plan (NTP), priority for screening of MDR-TB should focus on the following five high-risk groups: 1) retreatment and chronic patients; 2) smear-positive TB patients who are known to have close contact with confirmed MDR-TB patients; 3) TB patients who failed initial treatment; 4) patients who relapsed or returned after defaulting; and 5) TB patients who remain smear positive at month three. CAP-TB project follows the same standards for screening of MDR-TB.

Activity 2.2.1: Provide incentives for referrals of MDR-TB suspects and conduct regular feedback meetings among private and public sector health care providers

Multi-colored, carbon paper referral slips developed by FHI 360 were distributed to community outreach workers, private clinic physicians, pharmacy staff, and clinical staff at community health centers. When a patient is referred, the referee keeps one copy of the referral slip (green), the outreach worker another (pink), and the patient is given a copy to submit upon arrival to the appropriate health center (white), which ensures a free TB check-up. Outreach workers collate patient information in an A4 referral summary sheet; if a patient does not present at the referral site within one week, outreach workers conduct follow-up tracing. Private healthcare providers are provided with an incentive to participate in CAP-TB's referral system; these providers receive RMB 5 (US $0.79) for each referral that is taken up, and an additional RMB 10 (US$ 1.58) for each referred client who tests positive for TB.

FHI 360 staff conducted referral system training at the Fuhai RD CHC on November 9, as well as during two pharmacy training sessions, one in each target RD, on November 23 (see IR 1.1.4).

Activity 2.2.2: Train TB health staff in the detection and management of MDR-TB

On February 27 and 28, Dr. JIANG Chenyuan (The Union) conducted a training focused on the diagnosis and management of MDR-TB patients. A total of 44 staff (doctors and nurses) participated in this training (15 men, 29 women), of whom, one (2.3%) was from, the national level; 29 (65.9%) were provincial-level staff, 14 (31.8%) were Kunming municipal level (USAID PMP Indicator 18). The training focused on the most recent developments in MDR-TB treatment, management of clinical treatment, and treatment side-effects, and included a discussion of difficult MDR-TB cases, selected from among patient records at Kunming Municipal No. 3 People's Hospital.

Output 2.3: Strengthen human resource capacity for MDR-TB management

Activity 2.3.1: Support participation to attend National MDR-TB training conducted by NCTB

Beside a NCTB-The Union TB/HIV training (see IR 2.3.2), no appropriate training sessions conducted by NCTB were held. FHI 360 will continue to seek out and explore opportunities to support participants to attend MDR-TB trainings under IR 2.3.1.

Activity 2.3.2: Support participants to attend MDR-TB training conducted by The Union and WHO

NCTB-The Union TB/HIV Training: Xishan CDC Program Officer Mr. YAN Kai attended the Union-led National Center for Tuberculosis Control and Prevention (NCTB) HIV/TB co-infection training in Guiyang (Guizhou Province), from October 22 to 25, 2012. Mr. YAN presented what he learned at the FHI 360-organized HIV/TB grassroots organization capacity strengthening training on November 19 (see Activity 1.1.2).

The Union Budget and Financial Management Training Course: From March 24 through 30, FHI 360 supported four people to participate in a training course on budgeting and financial management conducted by The Union in Hangzhou (Zhejiang Province). The training brought together 28 health experts from around China who work on tuberculosis or tobacco control programs; two FHI 360 staff members attended, along with one staff member from Yunnan CDC and one from Xishan CDC. Led by Union consultants Mr. Solil KUMAR and Mr. Vinay CHOPRA, the course focused on the theoretical background of budgets and accounting, and included Excel exercises to put the theory into practice. Participants received three continuing educations credits.

Activity 2.3.3: Support participants to attend clinical management training for clinicians from GMs in Hong Kong

No relevant training sessions were held during the reporting period. FHI 360 will continue to seek out and explore opportunities to support participants to attend clinical management trainings under IR 2.3.3.

Activity 2.3.4: Provide laboratory training for lab technicians in Guangxi facility by Yunnan Anti-TB Association, Guangxi Anti-TB Association, and CAP-TB

Preparation of ISO 15189 Application: Mrs. Janet Robinson (Global Director, Laboratory Sciences, FHI 360 Asia Pacific Regional Office) provided laboratory technical assistance (TA) focused on quality and compliance during her visit from December 3 to 5. Seven laboratory technicians from the Yunnan CDC and Yunnan TCC TB laboratories participated. Mrs. Robinson also provided TA on using the GeneXpert machine, particularly in the detection of errors. Staff developed a two-year plan for FHI 360 assistance to the Yunnan CDC and Yunnan TCC TB laboratories for ISO 15189 accreditation, with future developments contingent on final approval from CAP-TB and USAID. Laboratory training was provided by Ms. SUNGKAWASEE, Senior Laboratory Specialist, FHI360 Asia and Pacific Regional Office
, in FY13 Q2 (see IR 2.1.2).

Output 2.4: Scaled-up quality treatment and community approaches for PMDT

Yunnan TCC Training: On December 11, three Yunnan TCC female nurses participated in a training on HIV palliative care, TB/HIV, and psychological support, led by Ms. LIAN Aizhu from the Hong Kong AIDS Foundation. The staff reported that the training was very important for understanding patients' perspectives, especially in reframing their understanding of noncompliance. Project staff are discussing conducting further trainings for all Yunnan TCC staff (i.e., doctors, nurses, and support staff) by Ms. LIAN in order to further strengthen human resource capacity for MDR-TB management.

Activity 2.4.1: Provide support to cover gaps in MDR-TB patient management

As the CAP-TB strategic model continues to be developed, FHI 360 will provide support to cover gaps in MDR-TB patient management, especially during FY13 Q4 as stated in the China Work Plan.

Data summary for IR2:

Indicator 13: Percentage of successful referrals.[4] Report by gender, referral source (outreach, private sector or lower level health care facility), and population group (migrant, prisoner, PLHIV, diabetic, elderly, close contact of TB/MDR-TB case, TB or MDR-TB case, general population or other)

By gender		**By referral Source**		**By population group**
M	57%(425/746)	**Outreach**	86% (25/29)	Disaggregation by population groups can't be made as the referral cards didn't tell.
F	43%(321/746)	**Private sector**	100% (276/276)	
		Lower level health care facility	93% (408/441)	

Indicator 16 (USAID PMP Indicator 14, 17, 18, 20) : Number of individuals trained. Report by training area BCC, infection control, referral, gender sensitivity (for example). For organizational development, the categories are: governance, administration, human resources management, financial management, organizational management, program management, or project performance management; level (national, regional or sub-national); sector (public or private); and gender.

# of individual trained	**# of individuals by gender**		**# of individuals by level**		**# of individuals by sector**		**Training Areas**
10	M	6	Provincial	7	Public	10	TB laboratory diagnosis;
	F	4	City/Community	3			
44	M	15	National	1	Public	44	Programmatic Management of MDR-TB MDR-TB case finding Adverse effect treatment
			Provincial	29			
	F	29	City/Community	14			
46	M	3	Provincial	4	Public	46	Monitoring and evaluation for CAP-TB
	F	43	City/Community	42			
1	M	1	City/Community	1	Public	1	HIV/TB Co-infection
2	M	1	Provincial	1	Public	2	Budget and financial management
	F	1	City/Community	1			
3	F	3	Provincial	3	Public	3	HIV palliative care, TB/HIV, and psychological support
30	F	30	City/Community	30	Public	3	TB knowledge, Referral of TB suspects

[4] Successful referrals are defined here as referrals which were provided and resulted in uptake of services by a client.

IR 3: Improved strategic information for MDR-TB

Output 3.1: Strengthened capacity of TB program to collect, use, and analyze data for management

A monitoring and evaluation (M&E) diagram was produced by FHI 360 to facilitate management and tracking of program data. A standardized binder for each of the different partners was produced by FHI 360 so that all relevant CAP-TB M&E materials could be easily stored in one place and provide a reference to partner M&E focal points.

Activity 3.1.1: Conduct external review of MDR-TB management in Kunming

From December 12 to 14, the Union-China Office Director Dr. LIN Yan visited CAP-TB sites to identify TA needs from the Union for FY13. During his trip, he met with representatives from Yunnan TCC, Yunnan CDC, Kunming CDC, Xishan CDC, and Kunming Municipal No. 3 People's Hospital. Before his departure, a TA plan was drafted which included training on case reviews, HIV and diabetes co-infection, and the nine-month treatment regimen.

Activity 3.1.2: Assist with the establishment of TB Working Group and conduct regular working group meetings

Project staff and local partners have established a CAP-TB working group that holds regular meetings attended by partners across all levels (i.e., FHI 360, Yunnan Anti-TB Association, Yunnan TCC, Yunnan CDC, Xishan CDC, RD CHC, and community outreach workers). Eleven people attended the October 17 working group meeting, while 14 people attended the November 27 meeting focused on M&E. Seventeen people, including CAP-TB Chief of Party Dr. Anh INNES (FHI 360 Asia Pacific Regional Office), attended the December 21 meeting focused on case discussion, outreach worker home visits, and preliminary analysis of 2012 TB Fuhai RD patient data (see IR 3.2.1).

Twenty-one people attended the February 6 working group meeting (five men, 16 women), including three FHI 360 Kunming staff, six provincial-level staff, 14 municipal or community-level staff, and one consultant. The main focus of the meeting was to present and discuss the results of the F&A review conducted by Ms. WANG (see "Program Management"), as well as to discuss ways to improve patient referral so more people could access free services available under Chinese TB control policies.

Activity 3.1.3: Provide TA for site supervision

Several CAP-TB partners undertook supervision activities:

Yunnan Anti-TB Association conducted nine supervision visits to Xishan CDC, Fuhai and Zongshuying RD CHCs, private clinics, private pharmacies, Yunnan TCC, and Kunming No.3 Hospital for financial management, patient management, TB services uptake, and biosafety and infection control.

Kunming Municipal CDC paid two site visits to Xishan District CDC, as well as the Fuhai and Zongshuying RD CHCs in November and December 2012. These visits focused on MDR-TB case finding, current TB patient treatment and management, referral and tracing of suspected cases, and records checking.

Xishan CDC conducted supervision and guidance for Fuhai and Zongshuying RD CHCs as well as ten private pharmacies and 20 private clinics through eight monitoring visits (see also Activities 1.1.3 and 1.1.4).

Regional Support to Country: Dr. Anh INNES visited Kunming from December 20, 2012 through January 7, 2013. During her visit, she visited the Kunming CAP-TB sites,[5] participated in the December CAP-TB working group meeting, and provided crucial feedback for work conducted since July 2012. In addition, Dr. INNES adapted and piloted the CAP-TB TRENDS module with the help of community outreach workers (see IR 3.2.1). As a result of discussion and site visits, programmatic management of drug-resistant tuberculosis (PMDT) will focus on the following high-risk groups: migrant/mobile populations, people living HIV/AIDS (PLHIV), the elderly, and diabetics.

Activity 3.1.4: Strengthen Data Quality Assurance (DQA) and data analysis to Yunnan CDC and Xishan CDC for data management

CAP-TB TB data is managed through the China CDC nationwide TB electronic reporting and recording system, in place since 2005. Future assistance to facilitate data use and gain a better understanding of the TB situation in Yunnan Province was requested by the CDC.

Development of Monitoring and Evaluation tools and procedures: Ms. Shanthi NORIEGA (Associate Director, Strategic Information, FHI 360 Asia Pacific Regional Office) visited the CAP-TB program from November 27 to 29. Day One was dedicated to M&E training, focused on basic principles and terms of M&E, logical frameworks, and challenges in program monitoring. On Day Two, staff conducted site visits to practice completing existing M&E forms and discuss potential improvements to those forms with outreach workers, Yunnan TCC doctors, and other project staff. On Day Three, Ms. NORIEGA worked with local staff to draft the China M&E plan and a description of the China referral tracking system. After the training, Mrs. LI Ling (FHI 360 Kunming) provided Yunnan TCC staff and community outreach workers with further M&E-related assistance, and received feedback which was used to adapt the tools for use locally.

FHI 360 Kunming Monitoring and Evaluation Program Officer: In January 2013, Mr. XU Zhixiang joined FHI 360 Kunming as a CAP-TB Program Officer (see "Program Management"). During FY13 Q2, Mr. XU Zhixiang has consulted local partners on their experience using CAP-TB M&E tools, and thereafter adapted the existing forms to clarify the purpose of such forms and provide detailed instructions for their proper completion. In addition, he fined-tuned the CAP-TB M&E system, including M&E data flow, clarified the roles and responsibilities of all local partners, designated M&E focal persons, and developed an Excel database to collate all M&E forms. Mr. XU and Ms. LI Ling provided a training of the adapted system for all local partners during the February 3rd and March 15th CAP-TB Working Group meetings (see IR 3.1.2).

Data Quality Assessment: From March 19 to 21, Ms. Shanthi NORIEGA accompanied the USAID Strategic Information Team (Ms. Ravipa VANNAKIT and Ms. Marisa SANGUANKWAMDEE) from Bangkok to Kunming in order to jointly conduct the first data quality assessment (DQA) for CAP-TB China. The designated M&E focal points from YATA, Yunnan CDC, Xishan CDC, Yunnan TCC, Fuhai and Zongshuying CHCs, and the community outreach workers and team leader attended the DQA interview led by Ms. NORIEGA on Day One. Ms. FEI Yiju, M&E focal point for Xishan Women's Federation, also attended as an observer. Through the DQA interview, it was concluded that CAP-TB China program has an overall solid M&E system, particularly in the establishment of M&E focal persons, clear roles and responsibilities of the different partners, and documentation tools in both English and Chinese.

On Day Two, a data validation exercise was conducted to examine three USAID indicators chosen for DQA: 1) number of people reached with TB prevention and treatment messages; 2) number of private sector partners working with NTP with USAID support; and 3) number of newly diagnosed MDR-TB

[5] That is, the Kunming Municipal No. 3 People's Hospital, Yunnan Health Bureau, Yunnan TCC, Yunnan AIDS Care Center, Kunming CDC, Xishan CDC, and Fuhai and Zongshuying RD CHCs.

patients initiated on treatment. While data validation found that M&E forms are correctly completed the majority of the time, the following key issues were identified for data collected by outreach workers: 1) Not all source documents were available for DQA, 2) 228 records for the last two weeks of December 2012 were missing from the database, and 3) 27 clients reached by community outreach workers were not reported in the final database. After the DQA activity, the community outreach team worked with FHI 360 to verify data and identified the problems that led to underreporting.

Based on the DQA results and recommendations, FHI 360 Kunming undertook 13 actions to improve the CAP-TB M&E system: 1) M&E responsibilities for outreach workers have been added to the M&E Roles and Responsibilities Sheet; 2) Data collection forms have been updated with additional information and will be used from April 2013; 3) A private partners tracking form was developed to track the involvement of private clinics and pharmacies, and will be used starting from April 2013; 4) YATA/Yunnan CDC will be responsible for reporting laboratory diagnoses; 5) The Q1 database was reconciled with the source documents and the missing data was identified; 6) The data in the FY13 Q1 quarterly report was revised and resubmitted; 7) An M&E-specific supervisory communication tree/reporting line will be developed in April 2013; 8) A supervisory diagram with focused on data quality and data flow will be developed in April 2013; 9) Data double entry for outreach will be carried out for four to six weeks; 10) Data verification will be carried out for both clinical and outreach data for three to four months; 11) An M&E standing agenda item will be included on monthly working group meetings. For the next two or three months, the meetings will follow up with the DQA recommendations; 12) A data validation "aide memoires" will be developed to guide outreach workers in their daily work;13) A second DQA will be conducted at the beginning of FY13 Q4.

Output 3.2: Increased TB research activity

Nine-Month MDR-TB Regimen: One of the objectives of Dr. JIANG Chenyuan's visit in late February (see IR 2.2.2) was to assess the feasibility of piloting short (e.g., nine months as opposed to 24 months) MDR-TB regimens in Yunnan Province, in collaboration with CAP-TB. On March 1, Dr. JIANG and Dr. LIN Yan (The Union) met with Dr. ZHA Shun (Deputy Director, Yunnan CDC), Dr. XU Lin (Chief, Tuberculosis Section, Yunnan CDC), FHI 360 staff (Ms. LI and Mr. XU), as well as high-level representatives from NCTB, Dr. CHEN Mingting (Vice Director, NCTB) and Dr. LI Renzhong (Chief, Section of Drug-Resistant TB, NCTB). While The Union experts identified several challenges in current MDR-TB control in Yunnan,[6] it was agreed by all that piloting short MDR-TB regimens in China is of prime importance, and moreover, that Yunnan will serve as the site for such piloting. A tentative plan was decided upon to: produce a first protocol draft by the end of March 2013, establish an executive committee and a steering committee, and more clearly lay out the roles and responsibilities of all partners (i.e., international, national, provincial, and local).

Activity 3.2.1: Disseminate gender assessment findings among partners in Xishan District

TB Trends Module: Dr. Anh INNES adapted a community survey to assess local knowledge, attitudes, and beliefs about TB (TB Trends module) during her December visit (see 3.1.3). Project staff piloted the survey with assistance from the four community outreach workers, CAP-TB-affiliated HIV CBOs, and additional personnel. A total of 54 pilot surveys were conducted.

In March, the module was further developed and standardized for implementation in the three FHI 360 CAP-TB countries, with the goal of conducting 410 surveys per catchment area per FY. On March 21, five outreach workers and two student volunteers were trained on survey protocols, and the following day began conducting the survey as part of World TB Day activities in Xishan District (see IR 1.1.7).

[6] Specifically, these challenges were: 1) low enrollment of diagnosed MDR-TB patients (40%), 2) high treatment drop-out due to adverse effects, and 3) substandard diagnosis and treatment at Kunming Municipal No. 3 People's Hospital.

Completed surveys were then scanned and sent electronically to the FHI 360 Asia Pacific Regional Office in Bangkok for data entry and analysis. By the end of FY Q2, 442 surveys were completed. Overall, respondents tended to have a secondary school educational level (44%), were employed (64%) and married (86%). Among the 442 participants interviewed, 149 (33.7%) had never heard of TB before with a significant gender difference between males (41%) and females (26%) (p-value 0.0012). In addition, participants demonstrated poor TB knowledge, with approximately half (52%) of those surveyed aware that cough with blood was a symptom of TB, and only 19% aware that weight loss was also a TB symptom. Lack of knowledge was also found in how TB is cured, with 48% of the participants reporting that Chinese medicine could cure TB.

Fuhai RD Preliminary Analysis: Through an informal affiliation with FHI 360, Mr. Emilio DIRLIKOV (PhD Candidate, McGill University) conducted a retrospective analysis of patients treated in Fuhai RD in 2012, as registered on the Chinese CDC national electronic reporting and recording system. Research was facilitated by Ms. MO Lijuan (Fuhai RD CHC) and Fuhai RD community outreach workers. The analysis focused on several variables: age, gender, place of household residence, patient and provider delays,[7] and patient costs.

More specifically, in 2012, 42 PTB patients were treated in Fuhai Residential District, of whom 59.5% were men, 45.2% were residents, 64.3% were smear-positive at treatment outset, and four were retreatment cases. The age distribution of non-local residents was significantly lower than that of residents (mean, 33.1 and 49.1, respectively; p= 0.0004).[8] While patient delays differed minimally for the six variables tested (range, 39.8-42.9 days), a higher percentage of residents received diagnostic confirmation (provider delay) before non-local residents. A higher percentage of non-local women experienced a longer total delay than all other tested groups. Finally, interviewed patients reported that the most difficult part of their illness experience had been the incurred financial hardship; self-reported expenses accounted for 30%-41.7% of self-reported average household annual income.

Mr. DIRLIKOV presented results at the December CAP-TB working group meeting, and prepared a report for FHI 360, to be shared with USAID and local partners. In 2012, 42 patients were treated in Fuhai Residential District, of which 59.5% were men, 45.2% were residents, 64.3% were smear-positive at treatment outset, and four were retreatment cases. The age distribution of non-local residents was significantly lower than that of residents (mean, 33.1 and 49.1, respectively; p= 0.0004). While patient delays differed minimally for the six variables tested (range, 39.8-42.9 days), a higher percentage of residents received diagnostic confirmation (provider delay) before non-local residents. A higher percentage of non-local women experienced a longer total delay than all other tested groups. Finally, interviewed patients reported that the most difficult part of their illness experience had been the incurred financial hardship; self-reported expenses accounted for 30%-41.7% of self-reported average household annual income.

[7] Patient, or health-seeking, delay refers to the period of time from the first recognized symptom to the initial visit to a healthcare center. Provider, or system, delay refers to the period of time from the patient's initial visit to confirmation of TB diagnosis.

[8] While several Chinese terms are used to refer to "non-local" residents (e.g., 流动人口, 非本地人, 外地人, 没户口的), what differentiates this group from local residents is a non-Fuhai Residential District household registration, or *hukou* (户口).

IR 4: Strengthened enabling environment for MDR-TB prevention and control

The CAP-TB project aims to provide a holistic strategy to further improve the current system of TB control and prevention by coordinating key stakeholders from government, civil society, and the private sector. In Kunming, the CAP-TB working group is the cornerstone of this approach.

Output 4.1: Improved capacity for National Tuberculosis Program (NTP)

All CAP-TBs activities are conducted in-line with the Chinese NTP. During the reporting period,

Output 4.2: Strengthened partnerships for quality TB care include the private sector

Activity 4.2.1: Conduct regular referral coordination meetings with private and public sector

Pharmacy Training Session: In order to strengthen cooperation with the private sector, CAP-TB held two training sessions on November 23 to introduce the CAP-TB project, coordinate referrals, and provide information on TB and MDR-TB more generally to pharmacies in the Fuhai and Zongshuying RDs. A total of 110 pharmacies were invited, and a combined total of 110 people representing 110 pharmacies attended (see also IR 1.1.4 and 3.1.3).

Xishan District Government-led Coordination Meeting: On December 14, a coordination meeting was held in Xishan District to discuss referral of clients with suspected TB infection. Deputy Director JIN Wen (Kunming Municipal Drug Administration Bureau) attended the meeting, providing governmental leadership and support for the involvement of pharmacies in TB and MDR-TB case-finding. There were more than 20 participants, including six pharmacy representatives.

National-level Commendation for CAP-TB: In keeping with Chinese laws governing the operation of foreign non-governmental organization (NGOs), on November 29 the Yunnan Anti-TB Association, as a CAP-TB partner, met with the National Ministry of Civil Affairs' Bureau of NGO Management and the Yunnan Provincial Department of Civil Affairs' Unit of NGO Management to review the FHI 360 CAP-TB project. The review found that CAP-TB is in complete accordance with national guidelines and, most encouragingly, deemed the project's model for comprehensive collaboration to be worthy of replication by other Sino-foreign NGO partnerships.

Activity 4.2.2: Conduct private/public sector experience sharing meeting

CAP-TB partners at all levels have conducted various activities to involve the private sector in TB prevention and control activities (see IRs 1.1.1, 1.1.3, 1.1.4, 2.2.1, and 4.2.1). As more private clinics and pharmacies are reached, FHI 360 plans to conduct IR 4.2.2 activities in FY13 Q4, as stated in the China Work Plan.

Narrative III: Challenges Encountered During FY13 Q1

Despite the many activities undertaken during the reporting period, several important challenges were also encountered, which have the potential to influence future project implementation. Three of these challenges are highlighted below.

CAP-TB Partners' Roles and Responsibilities

While project staff worked throughout FY12 to sufficiently clarify the roles and responsibilities of the multiple CAP-TB partners, ambiguity remains. Moving forward, it is necessary to provide strengthened project management guidelines which more clearly delineate roles, responsibilities and actions under the CAP-TB project. A patient flowchart was also developed to clearly outline services at the different

CAP-TB partner sites and the responsibilities of each CAP-TB service provider at every step along the continuum of outreach, diagnosis, and treatment (see IR 1.1.1).

Behavioral Change Communication Strategy

One key activity during this reporting period was to identify key sub-populations of interest under the CAP-TB project; now that these groups have been identified, a strengthened behavioral change communication (BCC) strategy is required to maximize effectively targeted service promotion and patient education for the different target audiences. This is an overarching concern, as a strengthened, diversified BCC strategy will serve to frame training, outreach activities, community campaigns, the development of materials, and identification of appropriate communication channels.

In terms of community outreach workers, a strengthened BCC strategy should focus on segmenting different primary audiences (e.g., mobile populations, PLHIV, diabetics), determining important secondary audiences (e.g., pharmacy staff, private clinicians), and on identifying appropriate channels (e.g., through home visits) for reaching these audiences. The development of appropriate standard operating procedures (SOP) for implementing this BCC implementation is also crucial.

In considering behavior change activities, additional attention should be given to TB patients in helping to improve treatment success. This may include: counseling patients on treatment adherence and sanitation habits, such as infection control in the home; personal hygiene, improved nutrition, and sufficient rest; working with Yunnan TCC staff to further elucidate issues affecting patient adherence and support; setting up a support hotline to properly refer patients and provide basic counseling services.

Private-Public Partnership (PPP)

Proper referrals from the private sector continues to be a challenge that will need to be addressed in FY13. The challenge is twofold. First, some private healthcare staff at pharmacies, clinics, or traditional medical practices may not be aware of the main symptoms of TB, the emergent challenge of MDR-TB, or how to appropriately initiate referrals. This challenge is being addressed by CAP-TB through community outreach workers' regular activities, as well as through invitation to training sessions for private pharmacies and clinics.

Second, the current CAP-TB incentives for private healthcare providers to refer patients with suspected TB infection (see IR 2.2.1) are seen as largely symbolic and may be insufficient to promote proper referral given potential revenues when private providers retain their patients. Further efforts should be made to understand the priorities of the private sector, and develop methods to incentivize proper referrals that are not strictly monetary. This may include: interviews with private sector staff, roundtable discussions, and specialized activities through community outreach workers. One potential alternative avenue could be official recognition for especially cooperative institutions in the private sector from CAP-TB governmental partners, such as the Health Bureau or Municipal Drug Administration Bureau.

Narrative IV: Snapshot

Stopping MDR-TB with FHI 360: Ms. Zhang's journey

FHI 360 supports first outreach team for community-based TB control and prevention

Ms. ZHANG Baoyun is a slight woman, short in stature but bubbling with energy and a bright smile. Born and raised in Kunming, Ms. Zhang watched as the rice fields that surrounded the city gave way to high rises and glitzy commercial areas, but her duties as a wife and mother precluded her taking part in these changes. "I was seeing such amazing changes going on all around me, but my life remained unchanged. As my son entered high school, I started to think about what else I might be able to do with my life, how I might contribute to improving my local community."

In July 2012, Ms. Zhang became one of China's first TB outreach workers as part the USAID/FHI 360 CAP-TB project. This team of four women reaches out to their communities to provide information on TB prevention, refer individuals with symptoms of possible infection to appropriate health institutions, and facilitate partnerships with the private health sector. The road has not been easy. Outreach workers encounter many people passing by as they try to convey important TB messages, and at times they are met with suspicious glances or curt responses.

Outreach workers have overcome many of these difficulties with communication training from CAP-TB staff. "Now when I go out to do my outreach activities, I know I can talk to people I come across," Ms. Zhang explained. "I have developed strategies to make people in my community understand the importance of stopping TB!"

This newfound confidence carries over into other parts of Ms. Zhang's life as well. "I used to be embarrassed that I did not have a job, that I was not serving as the best role model for my son. I am proud of my service to my community, and this work has helped me become a better person."

Annex I: Implementing Agencies of FHI360/USAID CAP-TB Program Organizational Capacity Assessment – China

A. Background on CAP-TB Capacity Development

The "Control and Prevention-TB" project, or CAP-TB, aims to decrease the incidence and mortality of MDR-TB in the Greater Mekong Sub-region. Capacity development of local implementing agencies partnered with CAP-TB in Burma, China, and Thailand is one of the project's key priorities with the goal to enable local partners to effectively manage direct funding from USAID.

FY 13 Quarter 1 and 2 update

In Q1 of FY13, FHI 360 began using the Organizational Capacity Assessment Tool (OCAT) to systematically assess the strengths and weaknesses of each implementing agency, creating baseline data to monitor capacity development over time. The OCAT provides a framework for an efficient system to develop capacity by setting the baseline for key capacity areas using a scoring system applied through self-assessment. This is followed by development of an action plan to improve the scores. The self-assessment tool and scores essentially provide a numerical indicator to enable quick assessment of an organization's capacity and its success in developing capacity over time.

In FY13 quarter 2 the CAP-TB Capacity Development Consultant conducted Organizational Capacity Assessments with the Yunnan CDC and YATA in Kunming at the FHI360 office.

Preparation and pre-assessment: The CAP-TB consultant introduced the package of OCAT tools to the FHI360 Kunming office and after its team review, the tool was then shared with YATA. The CAP-TB team also discussed the OCA process and set a timeline for assessment.

Assessment and validation: The CAP-TB team guided YATA through each step of the OCAT as they assessed seven key capacity areas and developed plans to increase their capacity to manage programs, deliver quality services and lead them towards greater sustainability. Specific action plan was developed and it is hoped that project tailored capacity development assistance will be provided to the partners in the upcoming quarters.

Although specific capacity development plan for YATA will depend on the resources and time available, activities currently anticipated in FY13 and FY14 for Kunming are presented in the attachment of the work plan. These activities will be revised if needed in collaboration with Yunnan CDC/YATA and USAID RDMA.

B. Organizational Capacity Assessment Tool (OCAT)

In order to track progress and maintain a results-focused approach, the CAP-TB team has adapted several commonly used USAID capacity building indicators to measure the performance of our organizational capacity development (OCD) work. The goal of these OCD indicators is to measure progress toward local capacity development.

As a way to keep track of the number of individuals within partner organizations that have benefitted from the project resources, the number of individuals who have received training, mentoring and any other support, by key capacity areas (below) will be counted. The capacity development effort will be geared towards sustainability of local partners, strengthening both the organizational systems as well as the human resources. The key capacity areas will depend on the results of the baseline assessments and issues identified by the implementing partners. Project resources to build capacity as well as the

commitment from the partners themselves will impact the degree to which the key capacity areas are strengthened.

1. Governance, Vision and Mission
2. Administration
3. Human resources management
4. Financial management
5. Organizational management/Program management
6. Project performance management
7. External Communications

A key measure of the capacity development of each partner is its movement along the following levels in the chosen capacity areas as applicable. In terms of all the CD TA recipients of CAP-TB program as a whole, the percentage of partners demonstrating similar movement along the respective capacity areas can also be tracked. :

Level 1: Beginning
At this level, organizations are just beginning work in the said capacity area.

Level 2: Developing
At this level, organizations show some signs of development within the capacity area, but still need considerable inputs and support.

Level 3: Developed
Partner organizations show results, and need less of supportive intervention. However, results are not always consistent.

Level 4: Model
Partner organizations have achieved their capacity development goals. No more intervention is needed at the current time.

Organizational Capacity Assessment of Yunnan Anti-TB Association (YATA)
OCAT was introduced to the YATA prior to the actual capacity assessment that happened on 31 Jan and 1 Feb, 2013. During the course of the two days, a three person FHI360 CD team including capacity development consultant from Bangkok, the CAP-TB Program Manager and Program officer facilitated OCA sessions. The sessions explored partners' existing capacity in seven key areas as well as the need for strengthening the CAP-TB project and to achieve long term program sustainability objectives.

YATA's senior leaders, including its director attended the OCA meet. From the discussions and participant comments, the leadership style of senior management appears to be partly participatory and they seem to actively listen to stakeholders for their opinions. People talked about how senior leaders were very kind and warm-hearted and easily accessible when needed. Despite these qualities, it was also observed that YATA's senior management do not get many chances to meet with the TB patients and the organization's staff on the ground. Furthermore, as senior management's leadership style is centralized, it is less participatory in its approach and does not always meet the needs of the field staff as well as the target beneficiaries.

In so much as the senior management decides regarding where the organization shall go in the future and all other YATA staff and stakeholders need to support the organization's vision and mission, there is

a need to make everyone more involved in the formulation of vision as well as execution of decisions. It will ultimately help YATA in strengthening stakeholders' understanding of their vision and mission.

The anti TB association does have its own organizational chart that outlines roles and responsibilities for those staff that feature in it. But, there are no clear lines of reporting and communication. OCA discussions brought to the surface the need for YATA leaders to spend more time with staff and volunteers. YATA employees follow individual monthly work plans for which needs to be updated each month and staff are managed through contracts wherein everyone has their own targets to meet and report on. Staff are expected to communicate when they come across any problems in meeting the targets. In terms of the need to improve, more of YATA's beneficiaries could be involved in conducting needs assessment, program planning, and in the implementation of program activities.

As part of the capacity assessment, the OCAT looks into human resources management abilities. At the Yunnan CDC level, as there were several provincial level participants at the OCA, there appeared to be fairly strong HR capability. For example, parts of the CDC have a very strict timesheet system using a finger print scanner and a procedure for online request of leaves. However, there are other parts of YATA as expressed by the OCA participants, where individuals don't even get to complete their own timesheets. Specific people are assigned to be responsible to manage timesheets on their behalf. The final approval of people's timesheets is given by the division supervisors. There is no verification procedure and people felt generally unhappy about it. Participants expressed the need to strengthen the technical (skills building) components while training or coaching staff in the area of their job performance.

Financially, YATA's systems are in conformity with that of Yunnan CDC and comply with the government rules and regulations. Some staff commented that its accounting and financial policies/procedures are far too complicated and not enough training is provided to staff.
With budgets for each project reflecting revenue and expenditures, at times the budget may not reflect revenue and expenditures exactly due to foreign exchange fluctuation. YATA follows its own procurement policies in practice although a written guidance does not exist.

The anti TB association does not have a specific and clearly defined evaluation plan. Projects are monitored using project specific indicators as per the work plans that are often drafted with donor funded programs and activities with guidance received from the donors. Staff at the OCA meet noted that there is a need to evaluate the appropriateness of indicators in the local context. YATA have M&E forms for data collection but are quite weak in terms of data collection and analysis, needing more training in this area. Also, there are no regular mechanisms to collect beneficiary feedback. The ability to connect with beneficiaries and ensure their feedback is taken into consideration was desired by the staff members.

Staff expressed that their current communication with beneficiaries can be ranked as being poor and said that they only understand the needs and concerns of their project stakeholder groups through mechanisms such as monitoring visits and interviews. This has left a desire among some staff to conduct more rigorous needs assessment for engaging with stakeholders more effectively. Participants stressed on the need for strengthening links with medical institutions and the government finance bureau in particular.

Discussions at the assessment meeting revealed that YATA do not have a systematic communication plan even though they do have some communication related activities in which they engage in the course of regular work. For example, TB related messages are disseminated through media, via internet and campaign activities on 24 March each year. YATA also use some IEC materials in their dissemination

and outreach work, but staff at OCA felt that there is a need for more to happen and desired to improve in this area. They also highlighted that staff no not receive any training and/or coaching in the area of effective external communication.

C. Prioritizing Capacity Development Areas

As presented in the previous section, each participating management and staff member from Yunnan Anti TB Association (YATA) gave their own scores to the specific benchmarks within the 7 capacity areas. This produced a ranking of the most important areas along with the ranking of the specific benchmarks within each area. Since CAP-TB program has specific priorities to address for Capacity Development, FHI360 facilitators encouraged the team members to reflect on those priorities along with YATA's long term priorities. As per the importance given on building sustainable local systems by USAID Forward, the consultant and FHI360 China office staff worked with the teams to develop a clear focus and consensus on three chosen areas for CD. Three areas were chosen for in-depth capacity development as per the organization's own assessment of what was needed the most leading to further direct funding by donors. Even though the team worked to develop consensus on these three areas, in the end each person cast their votes resulting in the following three areas being selected for priority CD in FY 13 and FY 14.

Selection of top 3 areas for Capacity Development

Every participating member was given an assessment form during the OCA meeting. The summary profile of the assessment form is presented in **Annex I**. Out of 4 possible scores ranging from 1-4, they each gave their preferred scoring to benchmarks within the 7 capacity areas. Two methods were used in coming up with final combined scores of the benchmarks for presentation in the report as well as documentation as OCA score. The first method was to select the score that was chosen by a majority of the total 12 participants at the OCA meeting. If there was a tie between two levels, the lower level score was chosen. An average of all the benchmarks scores was tallied as presented in the following table **(Table 1)**. Following the scoring, FHI360 team led a process of discussion and consensus building for agreeing on what the final three areas for capacity development would be. Participants tried to convince each other, often by using details from their everyday work experience and backed by data/evidence. In the end, there was voting. Detailed votes can be seen in **Table 2** and there are plans to address the top 3 priorities.

Table 1: Scores and ranking for prioritizing CD areas

Capacity Area & Scores	AREA 1 Vision/Mission Governance	AREA 2 Admin	AREA 3 HR	AREA 4 Finance	AREA 5 Org Mg	AREA 6 Proj Mg	AREA 7 Ext Com
	2.9	2.8	3.1	3.3	3.5	3.2	2.4
Priority ranking based on scoring	3	2	4	6	7	5	1
Priority ranking based on agreement		**2**	**3**				**1**

During the process of voting for the priorities, the team deliberated on each of the benchmarks presented within the OCAT and ranked them in the order of priority as well. These priorities were critical in formulating the results based work plan with clear milestones for the Capacity Development TA. These benchmarks are presented as targeted indicators for FHI360's capacity development work with YATA in the CD work plan for FY13 and FY 14 in **Annex III and IV.**

D. Priority Areas and Benchmarks

External Communication

External communication ranked highly in terms of YATA's capacity development priorities and scored 2.4 on average out of the 4.0 scale. Selected with the objective to communicate effectively with external stakeholders and increase awareness of the work that YATA carries out, the OCA participants selected a total of 4 benchmarks for strengthening. Benchmarks 1 (score 3), 2 (score 3), 4 (score 2) and 5 (score 2) were selected. Following are some of the activities YATA envision implementing with FHI360's CD TA between the second quarter of FY13 and end of FY14.

Communication plan with clear objectives, key messages, defined target audiences and action plan

An all staff consultation will held to understand communication needs along with key external stakeholders FGD to determine their need for key communication from YATA. Following this, a communication plan will be developed that has clear objectives, key messages, intended target audiences and a plan of action. The communication plan will be implemented and monitored regularly.

Effective use of good communication materials to increase awareness of YATA and its work

An assessment of the existing communication materials at YATA is planned following which a SOP will be developed for using communication materials effectively. Tailored communication materials will then be developed and their effective use monitored.

Regular sharing of relevant information with target audience

YATA and FHI360 volunteers taking on this task will list out all of YATA's annual meetings and events and also add to the list meetings that YATA do not currently attend so long as they are appropriate venues for enhancing external communication. Working with a communications TA, the team will then map appropriate materials to share at each one of the events/meetings and develop a goal of such sharing. The actual sharing will follow and assessment done at regular intervals.

Media is made aware of YATA's work and contacts YATA at times to comment on TB issues

YATA plans to form a group for leading a key meeting with the media in the next quarter of FY13. This group will also develop an agenda for the planned half-day meeting with the media. Once the meeting is held, YATA and media partners will develop an action plan as a follow up and engage with media regularly and effectively beyond the World TB days.

Human Resources Management

Human Resources Management was selected as one of the top three areas for capacity development by YATA. With an average score of 3.1 out of 4, the benchmarks that scored the lowest were 5 (score 2), 6 (score 3) and 7 (score 2). Detailed plans were made to address the challenges and ensure capacity development. Following are more details regarding the benchmarks and the work plan activities.

Adequate number of staff are working to achieve desired results

Assessment of the level of staff need and their training/coaching needs specific to each job role/expectation; development of job descriptions and roles/responsibilities as per org chart;
Hiring of new staff as per the assessment report (eg, lab- technicians) and training of project managers are some activities to address this area.

Staff provided with appropriate training and coaching on knowledge and skills needed for performing their roles effectively

YATA plans to utilize the inputs from the assessment report that will emerge as part of the first activity to come up with appropriate training/coaching for staff. Tailored and adapted training/coaching programs will also be implemented.

Managers providing staff with constructive feedback, appropriate supervision and adequate support

YATA envisions receiving support from FHI360 to adapt/develop a package to train managers on effective supervision and supporting staff and plans not only to deliver the training but also monitor it regularly.

Administration

Administration systems strengthening emerged as YATA's top capacity development priority as well. The 12 person YATA team at the OCA meeting comprising of staff from various backgrounds and duties chose a total of 4 benchmarks for addressing The CD needs. Benchmarks 1 (score 3), 4 (score 3), 5 (score 2) and 6 (score 2) were chosen. Further details on the benchmarks and the activities to address the capacity gaps are given below:

Clearly written and updated roles, responsibilities and expectations of each individual YATA staff

YATA will update job descriptions of staff as and when there are any changes to the roles assigned to them, OR, at least once every calendar year

Regular communication and sharing of information effectively through meetings, emails, reports

By activating and improving the existing QQ groups network and by increasing the number of group members, YATA plans to conduct regular communication effectively using meetings, emails, telephone, reports etc with a mission to strengthen regular communication.

Efficient decision making process with mechanisms to involve appropriate people as needed

YATA will request FHI360 for a TA to help review its existing administrative decision making process and get some recommendations to improve efficiency in its decision making processes. As a result of this activity, YATA hopes to revise its current decision making process, write it up as a Standard Operating Process, adopt it and implement it.

Participation of beneficiaries in assessment, planning, implementation and evaluation

To start out, YATA will list the stakeholders to invite to key program activities ranging from assessment, planning, implementation and evaluation and begin inviting stakeholders appropriately based on the listing and event type. Furthermore, efforts will be made to ensure that any recommendations beneficiaries make in these events will be followed through and the results made known in subsequent meetings.

Table 2: Detailed voting for prioritizing CD areas:

Details of Individual Votes on Priority CD areas								
S No	Name	Area 1: Governance Vision and Mission	Area 2: Administration	Area 3: Human Resources	Area 4: Financial Management	Area 5: Organization/Program Management	Area 6: Project Performance Management	Area 7: External Communication
1	MK		1	2				3
2	Yuki		3	1				2
3	Cherry	1		3				2
4	Huang Li		3	1				2
5	Yun		1	3				2
6	Yin Ting		3	1				2
7	Mali		3	1				2
8	Yongting		3	1				2
9	Yun		3	1				2
10	Xia		2	1				3
11	WY		1	2				3

E. Plan of Action for Organizational Capacity Development

YATA developed a detailed plan for addressing the capacity development needs mobilizing FHI360 TA. Refer to **Annex III-IV** for the **work plan** and **timeline**. The Annexes list details regarding planned activities, measurement benchmarks, timeline and responsible persons for taking forward the CD work plan.

THAILAND

Period covered: 1st October 2012 to 30th March 2013

Acronyms

BTB	Bureau of Tuberculosis
CAP-TB	Control and Prevention of Tuberculosis
DHO	District Health Office
DOT	Directly observed therapy
IEC	Information, education and communication
MDR	Multidrug resistant
NCCM	National Catholic Commission on Migration
NTP	National TB Program
PHO	Provincial Public Health Office
SHPH	Sub-district health promotion hospital
TB	Tuberculosis

Narrative I: Executive Summary

The Rayong Provincial Public Health Office (PHO) and the National Catholic Commission on Migration (NCCM) worked in close collaboration with partners at provincial, district and sub-district levels, municipalities and communities to implement the CAP-TB Project and CAP-TB strategic model in Rayong Province throughout Quarters 1 and 2 of FY13.

Overall, the Rayong PHO played a key role in leading and coordinating with health facilities at all levels in the project target areas. The PHO also provideed supportive supervision and case management support to health facilities and NCCM to ensure treatment adherence and success among tuberculosis (TB) and multidrug-resistant tuberculosis (MDR-TB) patients. Particular attention was paid to challenging cases, including patients with problems taking their medicines or who are difficult to follow up. For these cases, discussion and coordination through the multi-disciplinary MDR-TB case conferences led by Rayong Hospital and PHO have contributed to successful treatment.

NCCM led the implementation of the project's community component with support from Rayong PHO, health facilities, and partners in the project target areas (Ban Khai, Klaeng, Mabtapud, Phe, and Rayong). In particular, NCCM organized training and monitoring for village health volunteers (VHVs) and also conducted screening of potential TB patients among at-risk populations including diabetics, elderly people and migrant populations. NCCM also facilitated sputum smear testing and referral of potential patients from communities to facilities and vice versa and conducted directly-observed therapy (DOT) supervision visits to TB patients and MDR-TB patients. Local hospitals conducted TB screening among HIV-positive patients.

Narrative II: Challenges encountered during reporting period

1. The CAP-TB reporting forms require project-specific information (particularly relating to data disaggregation) which is different from those required by the National TB Program (NTP). This challenge contributed to a delay in data collection and reporting. The Rayong PHO has been, and will continue to, promote a common understanding and liaise between the hospitals and FHI 360 to clarify any questions related to the reporting forms.
2. The planned provision of a package of services for MDR-TB patients was delayed due to some items in the package requiring USAID approval.
3. Follow-up with MDR-TB patients is a challenge: it requires considerable time as patients live far away from each other and are scattered across the Province. Initially, this issue was a challenge particularly for NCCM in providing timely DOT services for MDR-TB patients. In response, NCCM communicated with the patients to adjust their medication schedule to ensure that project staff could arrive at the patient's home on time. Rayong PHO has faced the same challenge – staff can follow-up with two patients per day only if both live within Muang District – otherwise they can only conduct one home visit per day. Even with these challenges, however, Rayong PHO has been able to conduct follow-up visits to all patients as required.
4. As of March 2013, none of the Memoranda of Agreement (MOAs) have been signed, which has delayed the establishment of "Community TB Committees". NCCM has been able to implement activities in the absence of the signed MOAs, although implementation would be strengthened if supported by the Community TB Committees. It is expected that the final MOA signatures from the municipality offices in the four target areas within CAP-TB will be completed by quarter 3 of FY13.

5. MDR-TB patients require oral medication taken twice daily, as well as a daily injection delivered by a healthcare provider. Previously, oral medicines were given to the patients directly. It was therefore difficult for NCCM staff who were responsible for following up with patients to monitor their treatment adherence, as they needed to visibly monitor the patients taking their medicines. The DOT has been revised such that medicines are now distributed to sub-district health promotion hospitals/public health centers. MDR-TB patients are asked to go to the hospital for daily injections, at which time health center personnel can observe the oral medication administration. The patients' second daily oral dose is then collected by NCCM and delivered to patients' homes where they can directly observe their treatment.
6. Promoting treatment adherence for patients who live alone and have no income is challenging. NCCM is currently providing support to one new MDR-TB patient who has no income and lives alone 70 kilometers from Muang Rayong District. To ensure treatment adherence, NCCM coordinated with the local administration to provide transportation for the patient to their bi-monthly doctor's appointment at Rayong Hospital. NCCM also coordinated with the patient's neighbor to drive the patient to Panglad SHPH for daily injections.
7. DOT supervision for MDR-TB patients is a time-consuming and labor-intensive process. It requires persistence and commitment on the part of DOT supervisors as well as a good relationship between the supervisor and patient. Heavy workloads have resulted in considerable NCCM staff turnover. FHI 360 will work closely with NCCM on plans to encourage staff retention and to ensure the project maintains adequate capacity for smooth implementation in the event of turnover.

Narrative III: Program Performance during reporting period

Program Management

Conduct regular M&E visits and coordination meeting with partners

Shanthi Noriega, Associate Director, Strategic Information, FHI 360 Asia Pacific Regional Office (APRO) and Amornrat Anuwatnonthakate, Country Program Manager, CAP-TB Project (Thailand Program) trained CAP-TB implementing agencies (IAs) on the CAP-TB monitoring and evaluation (M&E) system and reporting forms. A total of 26 participants (four males, 20 females - Indicator 20) from Rayong PHO, Rayong Hospital and NCCM on December 13-14, 2012 participated. CAP-TB reporting forms were reviewed at this training; the forms were also revised based on the discussion with the partners, taking their input into consideration.

Conduct capacity building assessment

Siddhi Aryal, CAP-TB Capacity Building Consultant and Amornrat Anuwatnonthakate, Country Program Manager, CAP-TB Project (Thailand Program) conducted the baseline organization capacity assessment (OCAT) with the NCCM and Rayong PHO team in December 2012. The assessment was structured and organized in a way that facilitated the partners to reflect on their current capacity and prioritize areas for capacity improvement in the future. The organizational capacity assessment tool (OCAT) was used to assess areas of capacity development. There are a total of seven areas, namely 1) governance, vision and mission 2) administration, 3) human resources management, 4) financial management, 5) organizational management/program management, 6) project performance management and 7) external communications. The top three priority areas of Rayong PHO and NCCM are presented in the table below.

Partners / Areas for capacity development	Human Resources Management	Organizational Management/ Program Management	Project Performance Management	External Communications
NCCM	3	2		1
Rayong PHO		1	2	3

Recommendations for next steps to build the partners' capacity in these areas are shown below.

Areas for capacity development	**Recommended activities**
Financial management (FHI priority)	• Financial review has been done with NCCM and feedback was provided. FHI 360 is working closely with NCCM to provide support to strengthen their financial management and ensure compliance. A complete Financial and Administrative (F&A) review will be conducted with NCCM accordingly. • F&A review with Rayong PHO is scheduled in Q3.
Organization/program management	• Development and use of workplan as management tool. • Analyzing and update the job description of staff. • Stakeholder analyses and determination of their information needs. • Development of systems for generating regular programmatic reports/information for effective dissemination and sharing. • Development of M&E plan and system. • Orientation/coaching on data quality assessment (DQA) and effective data quality management.
External communications	• Adaptation and/or development and use of external communication plan and materials. • Training/coaching of key staff in media relations, holding effective external communication meetings and development of success stories and media releases.
Human resources management (NCCM only)	• Review and revise HR manual (including performance evaluation, updating procedures and protocols. • Orientation/coaching/training of key staff in implementing the revised protocols and procedures.
Project performance management (PHO only)	• Development of strategic approach and plan for project update sharing to national partners, NGOs and media. • Tracking of dissemination results to follow up on key outputs/outcomes of CAP-TB project. • Develop system to track progress of project activities.

During the reporting period, M&E related activities were organized through M&E training/visits by the Associate Director, Strategic Information, FHI 360 APRO and as part of the site visits conducted by the Country Program Manager.

FHI 360 will continue to work with Rayong PHO and NCCM to review the other recommendations in line with the CAP-TB project priorities.

IR1: Strengthened MDR-TB prevention

IR 1.1: Mobilized communities to advocate for and use TB service

Table1: Summary of Indicators and Achievements for IR1.1

Indicator	Number of People Reached
Indicator 2: Number of individuals reached with TB prevention and treatment messages, through outreach and small group activities.	A total of 3,796 persons were reached through small and large group activities and community radio. 1,580 persons reached through small and large group activities; 504 males, 1,076 females. Approximately 2,216 persons (10% of total populations), 1,119 males, 1,097 females) were reached through community radio.
Indicator 3: Number of individuals referred to TB- and MDR –TB related services.	Totally 362 persons referred; 257 males, 105 females. 343 referrals were made by lower level public healthcare facilities and provincial-level public hospital; 19 referrals were made through outreach activities.
Indicator 4: Number of IEC materials distributed through outreach and clinical interventions.	1,800 masks In Thai: 1,500 TB booklets 1,500 TB pamphlets In Cambodian: 300 TB booklets pamphlets

Activity 1.1.1: Develop a Memorandum of Agreement (MOA) to increase local political commitment

The Memorandum of Agreement (MOA) aims to introduce the CAP-TB project to the local authorities, to seek their support and cooperation for project implementation and to introduce the formation of the Community TB Committee. The MOA is the agreement between the Municipality, Rayong Hospital, District Health Office, Rayong Provincial Public Health Office, the SHPH and NCCM.

The draft MOA with Phe Municipality was discussed with the Director of Phe Municipality in September 2012, but signing was delayed when the director was changed. The draft MOA was discussed with the new director on October15. Two changes were made in response to comments from the Municipality: 1) to change MOA to Memorandum of Understanding and 2) to change clause 5.6 from 'To provide support to low-income TB patients who cannot work as a result of illness or who are requested by doctor to take leave through providing living support funds or arrange transportation for patients to go to the hospital,' to 'Recognize outstanding TB volunteers who support TB prevention activities in the community such as presenting certificates to recognize their efforts or publicize their achievement through the Municipality's website.'

The four MOAs with Phe, Ban Khai, Mabtapud and Klaeng have been signed by all partners, including NCCM, Rayong Hospital, district health office, municipality, and community hospital (district-level hospitals or sub-district health promotion hospital/community health center) and are now at Rayong PHO for signing. It is expected that all MOAs will be completely signed by quarter3 of FY13.

In the absence of PHO-signed MOAs, NCCM has implemented various activities with support from Rayong PHO, health facilities at all levels and municipalities. Activities included training for village health volunteers in the four target areas (Phe, Mabtapud, Klaeng and Ban Khai communities); TB screening among the target populations (HIV positive individuals, diabetics, elderly and migrant populations); and referral of suspected TB cases for diagnosis and treatment at the designated SHPHs and public health centers.

Activity 1.1.2: Appoint Community TB Committee

The Community TB Committee will include representatives from the Municipality, SHPH, Community Hospital, Rayong PHO, NCCM and community volunteers. The Committees will play a key role in promoting TB prevention and management in communities and solving problems as they arise. It is planned that the Committees will meet every three months. These Community TB Committees will be appointed once the MOAs are completely signed by all partners.

***Activity 1.1.3: Promote knowledge and awareness among the general public about TB/MDR*-TB**

NCCM distributed IEC materials through four main channels namely VHV training, screening among HIV-positive persons, diabetics, elderly persons, and migrants, home visits conducted by NCCM and VHVs, and World TB Day.

During the reporting period NCCM distributed Thai-language TB materials developed by the Bureau of Tuberculosis (BTB), as well as Thai/Khmer materials developed by the Raks Thai Foundation under the Global Fund project. A total of 1,800 masks, 1,500 sets of TB materials in Thai and 300 sets of TB materials in Khmer were distributed. Each set includes a TB booklet, pamphlet and mask. More copies of the materials are needed.

NCCM will explore if there is a need to develop additional TB materials in Q3.

Activity 1.1.4: Community outreach by community leaders and peer educators

NCCM provided TB/MDR-TB information through both small (less than 30 participants) and large group (more than 30 participants) activities on various occasions. For example, at the HIV-positive person support group meeting organized by the hospitals, at the meeting for elderly persons organized by municipalities, education session for potential diabetics and education sessions organized through Community Learning Center for migrants. During the reporting period, a total of 1,580 persons (504 males, 1,076 females) were reached with TB/MDR-TB information through both small and large group outreach activities (Indicator 2).

Village Health Volunteers (VHVs) provided TB/MDR-TB information to seven TB patients during their home visits. NCCM conducted home visits to these seven TB patients on a weekly basis to follow up on their health and to assess the VHV visits. From discussion with TB patients, it was found that the volunteers gave TB/MDR-TB information, discussed patients' health and provided infection control suggestions such as opening windows and doors and drying their bedding in the sun.

NCCM will support the VHVs to organize knowledge dissemination in communities. The activities are planned to be organized in Quarters 3 and 4. During Quarters 1 and 2, VHVs were requested to attend various trainings on seasonal diseases such as diphtheria, flu, dengue, etc. organized by District Health

Offices (DHOs) as part of their regular surveillance activities. The VHVs have not organized specific TB education sessions in their communities due to a scheduling conflict, thus these will be conducted in the last 2 quarters of FY13.

Activity 1.1.5: Organize events with partners to raise awareness of TB in the communities

NCCM distributed a CD on TB developed by the BTB to the community leaders in the four target areas to disseminate TB information in their community. The leaders played the CD over the community radio once a week. According to population registration of the four target areas, it is estimated that approximately 2,216 persons (10% of total populations, 1,119 males, 1,097 females) were reached. FHI 360 will assist NCCM to develop a follow-up plan on this activity to learn more about the specific information that the community have received from the community radio. Such follow-up will also help to inform future airings of TB information over the community radio.

Rayong PHO, Rayong Hospital and NCCM worked with the Foundation for AIDS Rights (FAR) to organize World TB Day events in Klaeng District (March 19), Muang District (March 22), and Ban Khai (March 25). In all three districts, the CAP-TB Project organized exhibition booths, games and TB/MDR-TB quizzes. CAP-TB supported 10 banners and joined a parade to raise community awareness about TB/MDR-TB prevention and control. Project staff also gave away T-shirts and water bottles at the CAP-TB exhibition booths. It is estimated that a total of 460 individuals (183 males, 277 females) participated in the World TB Day event organized in the three districts. Number of people reached through the World TB Day event is part of the numbers reported under activity 1.1.4 above.

Activity 1.1.6: Empower communities for the active involvement of TB and MDR/TB prevention

NCCM provided TB/MDR-TB information through a Community Learning Center (CLC) with support from the National Catholic Commission on Sea Farers (NCCS). TB/MDR-TB information/education for Cambodian migrants has been implemented through four NCCS volunteers who are also Cambodian and thus can communicate with the migrants.

In order to provide information to migrants more effectively, NCCM has also trained their own migrant health volunteers, including providing lessons in Thai language and computer use. NCCM currently has two active volunteers in Ban Phe, and they plan to train additional volunteers in Klaeng, Ban Khai and Mabtapud to support project implementation and the work of existing village health volunteers in the communities. A total of 71 migrants (39 males, 32 females) were reached through the CLC.

IR 1.2: Scale-up implementation of TB infection control in health facilities

Table2: Summary of Indicators and Achievements for IR1.2

Indicator	**Percentage of households reached**	**Remarks**
Indicator 6*:* Percentage of households with MDR-TB patients meeting quality infection control standards.	27%	The infection control checklist developed under the CAP-TB Project is being finalized and thus has not yet been used. In the meantime, NCCM has been using Rayong Hospital checklist to assess infection control in households. Three out of the total 11 MDR-TB patients met quality infection control practice in the checklist.

Activity 1.2.1: Develop a practical guide for infection control for TB in household

In December 2012, FHI 360 supported Rayong PHO, NCCM and other partners to develop a draft guide for TB infection control in households. This guide will be tested by health officers at all levels and NCCM staff.

Rayong PHO and NCCM will work with FHI 360 to review and revise the infection control guide in Q3.

Activity 1.2.2: Conduct Tuberculosis Infection Control training for Rayong health officers from provincial, district and sub-district level hospitals and NCC M staff

Rayong PHO in partnership with NCCM organized Tuberculosis Infection Control (TB-IC) training on February 6 for 100 participants (including 98 health officers (36 males, 64 females) and two NCCM staff (one male and one female) aimed at improving infection control practices in health facilities and households. According to the pre- and post-training evaluation, participants had better understanding about infection control principles and how they could improve infection control practices in their facilities. Of particular note, the hospitals have reorganized their waiting areas to isolate diagnosed or potential TB patients from other patients. They also have a better understanding about their roles in assessing and improving infection control during home visits.

Activity 1.2.3: Promoting infection control practice in households

Rayong PHO, NCCM and VHVs promoted infection control practice during their home visits to patients' homes. Their recommendations included open windows and doors and drying of bedding in the sun.

While the TB-IC practical guide is being finalized, NCCM has been using Rayong Hospital's TB/AIDS patient follow-up checklist to measure adherence to household IC standards. The checklist measures general living conditions with regard to infection control and includes standards around good ventilation, patient wearing a mask or covering their nose and mouth when coughing, and proper sputum containers. The checklist is also used to evaluate the patient's physical condition and (among PLHIV) ART adherence, identify unmet care needs and promote TB screening among the patient's close contacts.

During the reporting period, Rayong PHO conducted four home visits with four MDR-TB patients and NCCM conducted a total of 247 visits to two MDR-TB patients.

IR 2: Strengthen MDR-TB management

IR 2.2: Strengthened case-finding and referrals for MDR-TB

Table3: Summary of Indicators and Achievements for IR2.2

Indicator	Number of People Referred	Remarks
Indicator 13: Percentage of successful referrals.	Eighty-seven cases referred to the four hospitals (namely at Rayong, Mabtapud, Klaeng and Ban Khai hospitals) also received services at the hospitals on the same day when the referral forms were received. Of these 87 cases, 58 were males (all TB patients),	The majority of the referrals was made by the four hospitals to other hospitals in Rayong Province and was therefore not reported in the CAP-TB

	28 were females (two were TB contacts, the others were TB patients) and one MDR-TB patient. 75 cases were referred by lower-level healthcare facilities; four by private sector (all TB patients) and 11 by others including community and provincial-level hospitals and relative.	reporting forms.

Activity 2.2.1: Scale up early case detection of TB

The CAP-TB project focuses on TB screening and case detection among the re-on-pre groups. These groups refer to the following persons:

- ***'Re'* or retreatment** refers to relapse cases, cases that start treatment again after treatment failure and cases that start the treatment again after default;
- ***'On'* or on-treatment** are patients who are currently on treatment, but whose sputum smear test result remains or becomes positive at the end of month two or month five; and
- ***'Pre'* or pre-treatment** are patients who are at increased risk for TB, including close contacts of MDR-TB patients, HIV infected persons, diabetics, elderly people and migrants.

NCCM and VHVs used standardized screening forms developed under CAP-TB project to screen potential TB patients in the at-risk population groups namely diabetics, elderly people and migrant populations.

TB screening among people living with HIV is conducted at hospital ARV clinics by health officers. However, from the discussion between NCCM and Rayong PHO, this screening was a challenge because patients did not disclose to health officers that they had symptoms of potential TB infection. In response, it has been agreed that HIV-positive persons will be invited to NCCM trainings for village health volunteers so they have knowledge and are able to identify potential TB patients among their peers, for example through PLHIV support group meetings and activities. During the reporting period 84 migrants, 176 diabetics, 55 elderly persons and 33 general populations were screened.

VHVs conducted screening among elderly people in their communities. NCCM staff conducted screening among diabetics at diabetic clinics in Ban Khai Hospital, Klaeng Hospital, Mabtabpud Hospital and Phe Sub-district Health Promotion Hospital. NCCM worked with migrant health volunteers to conduct screening for potential TB patients among migrants in Ban Phe. The screening forms from VHVs and NCCM were submitted to healthcare providers who followed up with all potential TB patients.

Rayong PHO provided sputum collection containers to Rayong Hospital, Klaeng Hospital and NCCM (500 containers each) and coordinated with community hospitals in the communities and Rayong Central Prison to collect sputum samples from the patient's close contacts for diagnosis. During the reporting period, Rayong PHO coordinated sputum sample collection from close contacts of three MDR-TB patients. None of the tests were positive.

NCCM also coordinated sputum smear testing for seven potential TB patients and one close contact of MDR-TB patient. None of the tests were positive.

During the reporting period, a total of 112 tests (30 're' cases (27 males, three females), 23 'on' cases (16 males, seven females) and 59 'pre' cases (44 males, 15 females)) were performed on GeneXpert by Rayong Hospital (see Activity 2.2.2)

Activity 2.2.2: Perform GeneXpert test, culture and DST

One hundred and twelve GeneXpert tests were performed from October 2012 to March 2013. Of the total tests performed, 13 cases were positive for Rifampicin resistance (Indicator 7). Of these cases, 11 are men (three are new cases and eight are retreated), two are women (all are retreated cases); five are in Muang District, two in Mabtapud and Klaeng each, and one each in Wang Chan District, Ban Khai District (Rayong Central Prison), Ban Chang and on the border between Rayong and Chonburi provinces. One patient passed away before the treatment was initiated. The other 11 patients are now on treatment (Indicator 10) and one patient is scheduled to start her treatment by end of March 2013.

According to the national protocol for MDR-TB testing, confirmatory test (DST) is required for all cases regardless of the diagnosis method used (either conventional (culture) or molecular (GeneXpert) methods). One MDR-TB patient (male) did not have positive Xpert test result for Rifampicin resistance, but his DST result came back positive. Therefore, during the reporting period, there are a total of 14 MDR-TB patients.

Activity 2.2.3: Coordinate with partners to strengthen the linkage of referral system

During the reporting period, the provincial referral form has been used to refer cases. Rayong PHO will play a key role in encouraging the application of the CAP-TB referral form among the hospitals and promoting common understanding among all health facilities that participate in the project about the referral system implemented under the CAP-TB project.

Rayong PHO coordinated referral of TB/MDR-TB patients back to the community, which included discussing patient support with each patient's nearest SHPH and addressing any care and support problems or concerns.

During this reporting period, Rayong PHO followed up with healthcare providers to ensure successful referral of five MDR-TB patients back to their communities (three live on the border between Rayong and Chonburi provinces, one in Muang District, and one in Klaeng District). All patients are receiving care and DOT provided by the hospitals and NCCM.

NCCM coordinated with partners at all levels of the referral system, including collecting basic information about TB/MDR-TB patients from health care facilities, working with the PHO and District Health offices, municipality as well as SHPHs and health centers to conduct community visits (to visit to TB/MDR-TB patient's homes, to conduct screening and to organize small group (less than 30 participants) education activities.

IR 2.3: Strengthened human resource capacity for MDR-TB management

Table4: Summary of Indicators and Achievements for IR2.3

Indicator	**Number of individuals trained**	**Remarks**
*Indicator 1*6*:* Number of individuals trained.	**Please section Activity 2.3.1 (below)**	Report by training area BCC, infection control, referral, gender sensitivity (for example). For organizational development, the categories are: governance, administration, human resources management, financial management, organizational management, program management, or project performance management; level (national, regional or sub-national); sector (public or private); and gender.

Activity 2.3.1: Conduct training on TB and MDR-TB for health officers at provincial, district and community levels

This activity was not organized during the reporting period due to a scheduling conflict. The activity is planned for Q3.

Activity 2.3.2: Study tour for TB and MDR-TB management to learn from Chiang Mai's experience

With support from the CAP-TB project, 19 healthcare providers and Rayong PHO personnel (two males, 17 females) from Rayong Province and two NCCM staff (both females) participated in a study tour from November 26-28, 2012 to learn from Chiang Mai's experience in community-based TB/MDR-TB prevention and management. The team met with Chiang Mai staff and discussed their experience in working with partners, health facilities, local authorities, community leaders, and village health volunteers. They also visited Sankampaeng Hospital to learn about the Tuberculosis Chiang Mai (TBCM) software program and TB/MDR-TB management in Sankampaeng District. TB clinic nurses demonstrated how the TBCM is used, including reviewing data entry, TB report generating and presentation, and how to link data from the existing system and export data for the National Health Security Office (NHSO).

Participants also visited the Ontai Primary Care Unit and Ontai community to learn how to work with local authorities, community leaders, and village health volunteers. The village volunteers shared their experience and demonstrated how to work with communities on TB case finding, DOT and home visits.
The trip was a worthwhile investment, as the processes implemented to raise TB awareness among village health volunteers in Chiang Mai and to promote the role of village health volunteers in communities may be applicable to the target communities in Rayong.

Activity 2.3.3 Capacity building for village health volunteers and migrant health volunteers

NCCM with support from Rayong PHO organized training for village health volunteers in the four project target areas (Ban Khai, Klaeng, Mabtapud, and Phe). These volunteers play a key role in disseminating knowledge and information about TB/MDR-TB to households in their responsible area. Each volunteer is responsible for 10 to 15 households. These volunteers are also responsible for screening elderly people suspected of having TB and for providing DOT to new smear positive TB patients in their homes.

NCCM organized refresher training for the volunteers in Phe, Klaeng, Mabtapud and Ban Khai in Q2, FY 13. Sixty participants (45 village health volunteers and 15 HIV-positive persons) attended the training organized in each area, for a total of 240 participants (42 males, 198 females – Indicator 17). The trained village health volunteers will continue to conduct screening for potential TB patients among elderly people in the community while the trained HIV-positive people will conduct screening among HIV-positive people at HIV clinic in addition to the screening conducted by health officers.

Activity 2.3.4: Support three physicians to attend the Union course on Clinical Management of MDR-TB (TOT) in Bangkok, Thailand

The CAP-TB project supported three physicians (Drs. Yuthichai Kasetjaroen, Bralee Suntiwut and Chittima Thibbadee) (Indicator 18) to attend a five-day training course on MDR-TB clinical management conducted in Bangkok by the Union from November 5 to 9, 2012. The training covered various topics including drug-resistant tuberculosis case finding, principles of MDR/XDR-TB treatment, management of adverse drug effects, management of drug-resistant tuberculosis in patients with co-morbidity, HIV and drug-resistant tuberculosis, and management of contact with MDR-TB patients.

FHI 360 will continue to support these trained physicians to deliver further MDR-TB trainings to health providers in Rayong Province.

Activity 2.3.5: Support the Anti-Tuberculosis Association of Thailand (ATAT) to organize a clinical training on MDR-TB management

CAP-TB Project supported the Anti-Tuberculosis Association of Thailand (ATAT) to organize a symposium on MDR-TB clinical management for physicians from 12 regions in Thailand. The symposium was a three-day training and was organized during February 26-28 for 40 physicians (29 males, 11 females – Indicator 18). The symposium was aimed at building capacity of the participating physicians in providing care for and managing MDR-TB patients.

FHI 360 will continue to work with BTB and international partners including WHO and US CDC to develop follow-up plan to the selected provinces and to continue to provide technical assistance and to build their expertise in MDR-TB management.

Activity 2.3.6: Conduct TB/MDR-TB case conference

NCCM coordinated a case conference with health facilities, Rayong PHO and the DHOs to discuss the management of challenging cases, including patients who are difficult to follow up, do not receive continued care and treatment or have difficulty in taking medicines, to identify potential solutions. This case conference was organized on December 4, 2012, to discuss challenges surrounding patients' follow-up. Physicians, TB clinic staff of Rayong and Mabtapud hospitals, a social security officer and lab technician from Rayong Hospital, Rayong PHO and NCCM attended the meeting. Initially, both the hospital and NCCM were not able to contact the patient since he did not disclose his actual home address and avoided meeting with NCCM staff and TB clinic staff at Mabtapud Hospital. According to the discussion, issues were identified and a list of actions in response to each issue was agreed upon. The patient is now taking medicine and getting injection on schedule and is no longer avoiding NCCM staff.

Case conferences are planned one time per quarter. However, meetings may be organized more frequently as needed.

IR 2.4: Scaled-up quality treatment and community approached for PMDT

Table5: Summary of Indicators and Achievements for IR2.4

Indicator	**Number of People Reached**	**Remarks**
Indicator 17: Number of individuals received package of TB/MDR-TB service through USAID supported sites	11	The package of services for MDR-TB patients in Thailand consists of transportation costs, sputum AFB and culture cost and living support for drug adherence. During the reporting period, only the transportation costs and sputum test cost were provided. Therefore none of the 11 patients have received the complete package of services.
Indicator 19: Percentage of MDR-TB cases on MDR-TB treatment regimen with negative culture by six months. Report by gender.	0	Currently there are a total of 13 MDR-TB patients. None of them have completed six-month period of the treatment as of this report, with the longest treatment period being four months to date.
Indicator 20: Percentage of MDR-TB cases on MDR-TB treatment regimen who died by six months	0	

Activity 2.4.1: Strengthen community-based DOT

Rayong PHO and NCCM will adapt existing community-based DOT guidelines in Q3 with support from FHI 360.

The trained VHVs are responsible for providing DOT to new smear positive TB patients in the communities. Currently there are six volunteers who are DOT supervisors. NCCM staff conducted follow-up visits to patients' homes on a weekly basis. A total of 94 visits were conducted during the reporting period. NCCM visits showed that VHVs visited patients' homes and provided DOT every day. NCCM staff have provided DOT for MDR-TB patients once daily. During the reporting period, NCCM conducted 247 visits to two MDR-TB patients at their homes.

Rayong PHO follows up on TB/MDR-TB patients and with Rayong Hospital and community or sub-district health promotion hospitals to monitor side effects the patients are experiencing and inform patients about their health benefits. During the reporting period, Rayong PHO followed up on five MDR-TB patients and conducted home visits to two patients.

Activity 2.4.2: Provide package of services

The full nutritional/transportation package of services has not yet been provided to any TB/MDR-TB patients. Currently, CAP-TB has provided transportation costs to 11 MDR-TB patients and health officers to conduct DOT for the patients. The package of services is considered to provide both living support as well as incentive for patients to continue treatment, thus data for this indicator have been reported in the SAPR PMP (Indicator 17).

Activity 2.4.3: Refine the CAP-TB strategic model implementation in Rayong and scale up to new sites

In FY12, the CAP-TB strategic model was implemented in Phe. Rayong PHO and NCCM introduced the standard screening form developed under CAP-TB Project and active screening among the project's focused at-risk population groups, namely HIV-positive persons, diabetics, elderly persons and migrants to Phe SHPH. Training was provided to VHVs to promote their knowledge and understanding about TB/MDR-TB, screening for potential TB patients and referral of potential patients to hospitals for further diagnosis. NCCM worked closely with Phe SHPH and facilitated sputum smear testing and in some case took potential TB patients to hospital for further diagnosis. Hot line numbers were setup at Rayong Hospital and distributed to patients and other hospitals in the province. Currently, these numbers are intended to provide TB/MDR-TB patients convenient contact to the hospital to discuss their concerns in relation to their treatment.

In FY13, the implementation of the model has been expanded to cover Ban Khai, Klaeng and Mabtapud using the same strategy as described above for Phe. Specifically, Rayong PHO worked in close collaboration with NCCM to introduce the project's screening form and promote active screening among the target populations in Muang (Mabtaphud), Ban Khai and Klaeng. The training on TB/MDR-TB, screening and referral of potential TB patients was not only provided to the VHVs, but also HIV-positive persons to strengthen screen among their peers.

FHI 360 will continue to work with Rayong PHO and NCCM to further refine model implementation and to promote the use of CAP-TB screening form and TB IC practical guide and checklist in all four target areas.

IR 3: Improved strategic information for MDR-TB

IR 3.1: Strengthened capacity of TB programs to collect, use, and analyze data for management

Activity 3.1.1: Training on and implementation of ODPC 10 TB software

The Office of Disease Prevention and Control (ODPC) conducted a training on the use of their own TB case management and reporting software, from February 27-28, 2013, for 25 participants including health personnel from TB clinics, statistics officers and IT staff from hospitals at all levels within Rayong Province.

All hospitals, including Rayong PHO have started using the software, with some technical problems. In particular, not all functions of the ODPC 10 software are compatible with the software used in hospitals in Rayong Province (SSB and HSIP). As a result, some data needed to be re-entered into the program instead of being transferred from the previous program.

Activity 3.1.2: Conduct on-site mentoring to partners on data quality assurance (DQA) to build capacity for data use

Shanthi Noriega, Associate Director, Strategic Information, FHI 360 Asia Pacific Regional Office and Duanne Punpiputt, Country Program Manager for CAP-TB Project (Thailand Program) conducted a data quality assurance visit to Rayong Province from March 25-27, 2013 with Rayong PHO, NCCM and representatives from Rayong, Mabtapud, Klaeng and Ban Khai hospitals. The visit was aimed at assessing the monitoring and evaluation processes of the CAP-TB project in Rayong Province in order to provide guidance on how the system could be strengthened to provide valid, reliable, complete, timely, and precise data.

The visit included a review of existing monitoring and reporting systems and validation of reported data. An action plan in response to the DQA results and findings was discussed and agreed upon with the project partners. In particular, the following action items were agreed upon between FHI 360, Rayong PHO, the hospitals and NCCM.

- Document focal point and outreach worker/health volunteer M&E responsibilities;
- Document how supervision for data collection, management, and quality is carried out;
- Integrate and document data reviews/discussions into monthly CAP-TB team meetings;
- Recommend monthly reporting (instead of quarterly) for the next few months to assure forms are being filled out correctly;
- Follow up refresher to assure team is confident and knows what data is needed on what forms, and what the data sources are;
- FHI 360 should provide more on-going supportive supervision and assistance to assure partners are comfortable with reporting forms and M&E procedures;
- Ensure that all data are electronically backed up among all partners on a monthly /quarterly basis;
- Organize a space devoted to CAP-TB paper files;
- Standardize filing and storage of CAP-TB forms and electronic files and centralize storing of all e-files;
- Confirm everyone has all latest documents and that these are kept in a CAP-TB ring binder at all partner sites;
- Revise Q1 data and update with Q2 data for semi-annual report (SAR);
- Carry out a second DQA this fiscal year; and
- Review and revise the form layout for easier data recording.

Activity 3.1.3: Conduct site visits and strategic information (SI)-related monitoring for routine reporting

Since January 2013, Duanne Punpiputt, Country Program Manager for Thailand Program conducted regular site visits every two weeks to Rayong Province. The support provided during the reporting period however has been focused on activity implementation. For Quarters 3 and 4, additional focus will be placed on monitoring of routinely reported data and capacity building to partners to improve project and program management.

IR 3.2: Increased TB research activities

Activity 3.2.1: Disseminate gender assessment findings among partners in Rayong Province

Implementation of the TB Trends survey was started in Q2 and will be completed in Q3. Analysis of the survey by gender will be done, as has been done in China and Burma, which will inform the qualitative studies on gender that will be done in Q4.

According to the discussion with Rayong PHO, the Center for Health Policy Studies/Faculty of Social Sciences and Humanities at Mahidol University, under a joint cooperation project with the Bureau of Tuberculosis (BTB) (Department of Disease Control, Ministry of Public Health with Global Fund funding (round 8)), are implementing a project to strengthen the quality of TB control in marginalized population and through community empowerment. The project explores gender-sensitive TB/HIV/AIDS service delivery and building capacity of healthcare providers in providing the services in gender-sensitive manner/aspect. The project is implemented in Muang Districts of five provinces in Thailand, including Rayong. To date, meetings with the management of hospitals and gender and TB experts in the selected districts were organized to introduce the project and to raise awareness about the importance of gender sensitivity in providing TB/HIV/AIDS services. Capacity building activities were organized for healthcare providers to build their capacity in providing gender-sensitive TB/HIV/AIDS services. During March – May 2013, the project plans to monitor changes in gender-sensitive service provision and to document challenges faced and in the final phase of the project (May- June 2013), the project will summarize the outcomes of gender-sensitive TB/AIDS services with a special focus on the integrated TB/AIDS care, MDR-TB patient care and patient and community empowerment in TB control.

CAP-TB Project will work with Rayong PHO, Rayong Hospital and NCCM to identify any gaps or potential areas where the project could contribute further on gender-sensitive TB issues.

IR 4: Strengthened enabling environment for MDR-TB

IR 4.1: Strengthened partnerships for quality TB care, including private sector

Activity 4.1.1 Coordinate with private sectors to implement the MDR-TB prevention and management of adverse drugs reaction in MDR-TB patients and infection control in health facilities and households

Rayong PHO plans to work with two private hospitals (Ruam Paett physician association and Mongkut Rayong hospitals) on MDR-TB prevention and management. These two hospitals provide care for patients who are covered under the social security scheme, which most TB patients are. During this reporting period, Rayong PHO provided screening and referral forms to both hospitals and will continue to engage them further. To date, no potential TB patients have been referred from these two hospitals.

Narrative IV: Snapshot

Case conference, an important tool to promote treatment success among MDR-TB patients

Chai (not his real name) was recently diagnosed with multidrug-resistant tuberculosis (MDR-TB) by Rayong Hospital, Rayong Province, a province in central Thailand. While more difficult and time-consuming to treat than drug-sensitive tuberculosis, MDR-TB is a curable disease, so long as patients take the right medicine, the right way, for the right amount of time. Unfortunately for Chai, his doctors could not track him down to make sure he was sticking to his treatment.

Helping MDR-TB patients adhere to their treatment is one of the key goals of the USAID-funded Control and Prevention of Tuberculosis (CAP-TB) project being implemented by FHI 360 and local partner agencies in Rayong. A full course of treatment can take as long as 24 months, and FHI 360 has trained clinicians and village health volunteers to follow-up regularly with patients to make sure they are taking their medicine the right way. Loss to follow-up is a key challenge, however; fearing discrimination, patients like Chai may avoid meeting with TB staff and don't disclose their real home address or telephone number, making it difficult for healthcare workers to track their progress and replenish their drug supplies.

Prior to the CAP-TB Project, case conference was an internal meeting among Rayong Hospital personnel. Under the CAP-TB Project, case conference was introduced to bring together a multi-disciplinary team (including physicians, social security officers, lab technicians of Rayong Hospital) as well as representatives from Rayong PHO, DHOs, lower-level health facilities, municipalities, and NCCM to work in close collaboration, to discuss patients who are (for example) lost to follow-up or having difficulty taking their medication and together identify potential solutions.

In Chai's case, a case conference was organized in December 2012, which identified a number of underlying issues that led to improvements in client record-keeping and hospital protocols. These issues included incomplete collection of patient information (only street names were provided, no house number); lack of communication between Rayong Hospital and the lower-level hospital (located in Chai's residential area), the local TB clinic was therefore unaware that the patient had MDR-TB; arrangement of patient medicine (Chai was provided with a one-month supply, meaning he did not need to return to the clinic) and poor communication between healthcare workers and patients about the importance of treatment follow-up and support.

As a result of Chai's case, participants in the case conference agreed that hospitals will work to ensure that each patient's contact information is complete. It was also decided that the hospital will keep MDR-TB patients' medicine and that village health volunteers will deliver the treatment as part of their follow-up activities, to ensure they maintain contact with patients.

It took CAP-TB staff and partners roughly two months to verify Chai's contact information and initiate follow-up, but the good news is he is now taking medicine and receiving injections, and with an understanding of the importance of treatment follow-up he no longer avoids health volunteers. Thanks to the case conference system, Chai is well on his way back to health, and systems have been strengthened so that future patients don't become losses to follow up.

Annex I: Method used to estimate total number of individuals served (Narrative)

The Number of people received TB/MDR-TB prevention and treatment message through community radio was estimated on 10% of total population in the target communities (based on population registration).

Annex II: Implementing Agencies of FHI360/USAID CAP-TB Program Organizational Capacity Assessment – Thailand

A. Background on CAP-TB Capacity Development

The "Control and Prevention-TB" project, or CAP-TB, aims to decrease the incidence and mortality of MDR-TB in the Greater Mekong Sub-region. Capacity development of local implementing agencies partnered with CAP-TB in Burma, China, and Thailand is one of the project's key priorities with the goal to enable local partners to effectively manage direct funding from USAID.

In Q1 of FY13, FHI 360 began using the Organizational Capacity Assessment Tool (OCAT) to systematically assess the strengths and weaknesses of each implementing agency, creating baseline data to monitor capacity development over time. The OCAT provides a framework for an efficient system to develop capacity by setting the baseline for key capacity areas using a scoring system applied through self-assessment. This is followed by development of an action plan to improve the scores. The self-assessment tool and scores essentially provide a numerical indicator to enable quick assessment of an organization's capacity and its success in developing capacity over time.

FY 13 Quarter 1 update

During this reporting period, in Thailand, the CAP-TB Capacity Development Consultant has conducted Organizational Capacity Assessments with the following partner organizations:

- National Catholic Commission on Migration
- Rayong Provincial Health Office

Preparation and pre-assessment: The CAP-TB consultant introduced the package of OCAT tools to the Thailand implementing partners, discussed the process, formed functional area teams and set a timeline for assessment.

Assessment and validation: The CAP-TB team guided the two implementing partners through each step of the OCAT as they assessed seven key capacity areas and developed plans to increase their capacity to manage programs, deliver quality services and lead them towards greater sustainability. Specific action plans have been developed and tailored capacity development assistance will be provided to the partners in the upcoming quarters.

Although specific capacity development plans for each partner will depend on the resources and time available, activities currently anticipated in FY13 and FY14 for Thailand are presented in the attachment of the work plan. These activities will be revised if needed in collaboration with the partners and USAID RDMA.

B. Organizational Capacity Assessment Tool (OCAT)

In order to track progress and maintain a results-focused approach, the CAP-TB team has adapted several commonly used USAID capacity building indicators to measure the performance of our organizational capacity development (OCD) work. The goal of these OCD indicators is to measure progress toward local capacity development.

As a way to keep track of the number of individuals within partner organizations that have benefitted from the project resources, the number of individuals who have received training, mentoring and any other support, by key capacity areas (below) will be counted. The capacity development effort will be geared towards sustainability of local partners, strengthening both the organizational systems as well as the human resources. The key capacity areas will depend on the results of the baseline assessments and issues identified by the implementing partners. Project resources to build capacity as well as the

commitment from the partners themselves will impact the degree to which the key capacity areas are strengthened.

1. Governance, Vision and Mission
2. Administration
3. Human resources management
4. Financial management
5. Organizational management/Program management
6. Project performance management
7. External Communications

A key measure of the capacity development of each partner is its movement along the following levels in the chosen capacity areas as applicable. In terms of all the CD TA recipients of CAP-TB program as a whole, the percentage of partners demonstrating similar movement along the respective capacity areas can also be tracked. :

Level 1: Beginning
At this level, organizations are just beginning work in the said capacity area.

Level 2: Developing
At this level, organizations show some signs of development within the capacity area, but still need considerable inputs and support.

Level 3: Developed
Partner organizations show results, and need less of supportive intervention. However, results are not always consistent.

Level 4: Model
Partner organizations have achieved their capacity development goals. No more intervention is needed at the current time.

Organizational Capacity Assessment at RPHO
On 6 and 7 December 2012, the OCAT was introduced to the RPHO team. FHI360 CD team facilitated a series of team meetings to explore the existing capacity in key areas as well as the capacity development needs for strengthening the CAP-TB project as well as achieving long term program sustainability objectives. A lot of emphasis was given in gaining mutual trust so that honest discussions could be had in sensitive areas of capacity needs. The RPHO team felt that the Provincial Medical Officer's strong support was its strength along with the strong team within the RPHO. These strengths enabled it to carry out policy development and implementation. In terms of areas of improvement, the team felt that it needed to do some work to improve bottom up planning and programming. There was also discussion on improving external communication and partnerships in general.

RPHO team selected three areas for capacity development in the end. The priorities were set as 1) Organization/Program Management, 2) Project Performance Management, and 3) External communication. The action plan and timeline was set up following the priority areas with Rayong team. This report details the process of selection of these priority areas and provides the initial action plan to address the capacity needs.

Organizational Capacity Assessment at NCCM

In FY13 Q1, NCCM underwent a participatory Organizational Capacity Assessment process using the FHI360 tailored capacity assessment tool. As noted earlier, the tool has seven broad areas of capacity assessment for staff and management to vote. NCCM selected three priority areas for focused capacity development, in decreasing order: external communications, organizational/program management, and human resource management. After selecting the priority areas of capacity development, staff and management further prioritized the specific interventions they needed the most. One critical component necessary for maximum efficiency and cost-effective use of resources was ensuring high-level commitment from NCCM.

C. Prioritizing Capacity Development Areas

As presented in the previous section, each participating management and staff member of both RPHO and NCCM gave their own scores to the specific benchmarks within the 7 capacity areas. This produced a ranking of the most important areas along with the ranking of the specific benchmarks within each area. Since CAP-TB program has specific priorities to address for Capacity Development, FHI360 facilitator encouraged the team members to reflect on those priorities along with the long term priorities of the organizations. As per the importance given on building sustainable local systems by USAID Forward, the consultant worked with the team to develop a clear focus and consensus on three chosen areas for CD. Three areas were chosen for in-depth capacity development as per the organization's own assessment of what was needed the most leading to further direct funding by donors. Even though the team worked to develop consensus on these three areas, in the end each person cast their votes resulting in the following three areas being selected for priority CD in FY 13 and FY 14.

RPHO: Selection of top 3 areas for Capacity Development

Every participating member was given an assessment form during the OCA meeting. The summary profile of the assessment form is presented in **Annex I**. Out of 4 possible scores ranging from 1-4, they each gave their preferred scoring to each benchmark within the 7 capacity areas. An average of the scored was tallied as presented in the following table. Following the scoring, FHI360 team led a process of discussion and consensus building for agreeing on what the final three areas for capacity development would be. Participants tried to convince each other, often by using details from their everyday work experience and backed by data/evidence. In the end, there was voting. Detailed votes can be seen in Table 2. However, the results of the voting only reversed the order of the top 3 priorities, which are all planned to be addressed.

Table 1: Scores and ranking for prioritizing CD areas

Capacity Area & Scores	AREA 1 Vision/Mission Governance	AREA 2 Admin	AREA 3 HR	AREA 4 Finance	AREA 5 Org Mg	AREA 6 Proj Mg	AREA 7 Ext Com
	3.3	2.9	3.0	3.7	2.8	2.7	2.4
Priority ranking based on scoring	6	4	5	7	3	2	1
Priority ranking based on voting					**1**	**2**	**3**

During the process of voting for the priorities, the team deliberated on each of the benchmarks presented within the OCAT and ranked them in the order of priority as well. These priorities were critical in formulating the results based work plan with clear milestones for the Capacity Development TA. These benchmarks are presented as targeted indicators for FHI360's capacity development work with the partners in the CD work plan for FY13 and FY 14 in **Annex 1.**

RPHO Priority Areas and Benchmarks

Organizational/Program Management

Organization/Program management received the III highest ranking in terms of the scores. Sensing the critical role played by the area, the participants discussed the many ways in which FHI360 capacity development TA could be mobilized to help the CAP-TB project increase its efficiency and improve the results. As a result, the following 5 benchmarks were prioritized within this capacity area.

- Effective use of the written work plan as a management tool to track progress, identify problems and resolve issues.
- Staff provided with appropriate training and coaching in program planning, budgeting, implementation, monitoring and reporting
- Staff understand their individual roles and responsibilities as well as those of their colleagues, and work well both individually and as a team.
- Regular collection of feedback from beneficiaries on the quality of our programs and activities.
- Use of information from monitoring and evaluation activities in making adjustments and improvements to programs.

Project Performance Management

Project Performance Management ranked II in the order of importance given by the participants of the OCA meeting for capacity development. Participants discussed in detail regarding all the aspects of project management citing examples and drawing upon the lessons learned during the course of their everyday work. Out of the total of 5 benchmarks, the RPHO assessment team chose 3 benchmarks as follows:

Strengthening partnership within government and collaborating agencies and managing relationships effectively to better serve project beneficiary groups.
Deliver quality services to project stakeholders with measures to ensure meeting and/or exceeding of the requirements and expectations.
Track progress of project activities with a measure of timelines to ensure on-time delivery of project services.

External Communication

With only two people assigned to manage the entire communication portfolio of the Public Health Office in the province, the team talked about the various challenges faced. Even though the monthly newsletters are regularly produced and any urgent disease outbreak type of communication is prioritized, the consequence of not having a clear plan and dedicated personnel with good training has been the current state of the website that needs to be updated, brochures that need to be current, and other IEC and print materials that have not been produced. The biggest gap was noted to be the inability of the team to produce locally needed and tailored messages on specific disease areas, such as TB. In order to address these issues, the team scored External Communication as the most important priority, and voted for it to be the number three area for Capacity Development prioritizing the following benchmarks:

- Existence and effective use of good communications materials (e.g., website, brochure, newsletter, other print materials) to increase awareness of organization and work.
- Provide staff with adequate training/coaching on knowledge and communications skills needed to explain and promote work externally.

- Regularly share relevant information with target audiences.
- Appraise media of work and are contacted by media for comments on relevant issues

Table 2: Detailed voting for prioritizing CD areas

Result of RPHO Voting on Priority CD areas								
S No	Name	Area 1: Governance Vision and Mission	Area 2: Administration	Area 3: Human Resources	Area 4: Financial Management	Area 5: Organization/Program Management	Area 6: Project Performance Management	Area 7: External Communication
1	Tu	6	5	4	7	1	2	3
2	Brae	1	2	5	7	3	4	6
3	Jaruwan	4	5	6	7	1	2	3
4	Pued	6	5	4	3	7	2	1
5	Oh	3	5	6	7	2	1	4
6	Tuk	5	4	6	7	1	2	3
7	Chittima	6	5	3	7	1	2	4
						First Priority	Second Priority	Third Priority

NCCM: Selection of top 3 areas for Capacity Development

NCCM OCA participants were all given assessment forms during the OCA meeting. The summary of the scores given by the participating team is included with this report in **Annex I.** Out of 4 possible scores ranging from 1-4, participants each gave their preferred scoring to each benchmark within the 7 capacity areas. The average of the scores is presented in the Table 3 below. During the OCA process, there was a lot of emphasis on consensus building and understanding of the rationale of why certain members scored benchmarks in one way or another. Following the scoring and the team discussions, the team members all voted. Details of the votes are presented in Table 4, following Table 3 below.

Table 3: Scores and ranking for prioritizing CD areas

Capacity Area & Scores	AREA 1 Vision/Mission Governance	AREA 2 Admin	AREA 3 HR	AREA 4 Finance	AREA 5 Org Mg	AREA 6 Proj Mg	AREA 7 Ext Com
	3.63	3.18	3.13	3.90	3.44	3.83	3.0
Priority ranking based on scoring	5	3	2	7	4	6	1
Priority ranking based on voting			3		**2**		**1**

Within the top three priority areas for capacity development presented below, FHI360 TA encouraged the NCCM team to further prioritize a number of benchmarks so that clear action-steps could be taken to implement capacity development work plan achieving results. These benchmarks are presented as

targeted indicators for FHI360's capacity development work with the partners in the CD work plan for FY13 and FY 14 in **Annex 2.**

NCCM Priority Areas and Benchmarks

External Communication

External Communication emerged as the number one priority for the NCCM CAP-TB team. Of the 5 benchmarks contained within, the team decided to focus on the following three for developing detailed CD plan for receiving FHI360 CD assistance going forward.

- Adaptation/Development and effective use of good communications materials (e.g., website, brochure, newsletter, other print materials) to increase awareness of organization overall and CAP-TB related work specifically.
- Staff provided with adequate training/coaching on knowledge and communications skills needed to explain and promote CAP-TB work externally.
- Relevant information shared regularly with target audiences.

Organizational/Program Management

Even though HR and Administration received the II and the III highest ranking in terms of the scores, the voting results established Organization/Program Management as the second area of priority capacity development for NCCM. There was a lot of discussion on sustainability and the team's desire to potentially access USAID and other donor support by further strengthening this area. The following total of 5 benchmarks was prioritized within this capacity area.

- Development and use of written work plan that clearly states key tasks, timelines, and responsible individuals.
- Use of clear and relevant results-based indicators and targets used to monitor progress.
- Development of program monitoring and evaluation plan and use before beginning implementation of any programs and activities.
- Clearly written instructions and procedures for collecting and reporting data and orientation to staff on its consistent use
- Use of information from monitoring and evaluation activities in making adjustments and improvements to programs.

Human Resources

NCCM team at the OCA meeting highlighted the key importance that HR plays in the organization. This area received a score of 75% and was selected as a priority for further strengthening. Three benchmarks, as follows, are selected for further development into work plan and deliverables.

Updated and written HR policies and procedures that are in compliance with laws and are consistently followed

Annual or semi-annual review of each employee's performance conducted and feedback as well as support provided for performance improvement.

Staff provided with appropriate training and coaching to enhance knowledge and skills needed for performance improvement.

Table 4: Detailed voting for prioritizing CD areas:

Details of Individual Votes on Priority CD areas								
SNo	Name	Area 1: Governance Vision and Mission	Area 2: Administration	Area 3: Human Resources	Area 4: Financial Management	Area 5: Organization/Program Management	Area 6: Project Performance Management	Area 7: External Communication
1	Pat	6	4	3	7	1	5	2
2	John	2	1	4	3	5	6	7
3	Sunya	6	2	3	7	4	5	1
4	Aumnaj	3	2	1	7	5	6	4
5	Sa.	7	6	4	5	3	2	1
6	Ying	6	2	3	7	4	5	1
7	Doroteo	5	3	4	7	1	6	2
8	Noi	4	3	1	7	5	2	6
9	Pipat	2	4	3	7	6	5	1
				Third Priority		Second Priority		First Priority

D. RPHO and NCCM Plan of Action for Organizational Capacity Development

Both organizations developed detailed plans for addressing the capacity needs mobilizing FHI360 TA for capacity development. Refer to **Annex IV** for RPHO work plan and **Annex V** for NCCM work plan. The Annexes list details regarding planned activities, measurement benchmarks, timeline and responsible persons for taking forward the CD work plan.

E. Results of CD

The OCAT for CAP-TB addresses the following seven areas of organizational capacity:

1. Governance, Vision and Mission
2. Administration
3. Human resources management
4. Financial management
5. Organizational/Program management
6. Project performance management
7. External Communications

FHI360's CD efforts are focused on contributing towards developing strong, effective and sustainable partner organizations. The approach is flexible and enables each partner to choose its own areas of priority and benchmarks. FHI360 then tailors the CD interventions for each partner. Given the tailoring of the tools and approaches, every organization charts its own course and generates CD outcomes. The following table outlines some of the general potential results of capacity development efforts.

OCA Component	Developing this area will:	And this will:
Governance, Vision and Mission	Provide a clear long term direction - and a way of getting there	Help improve services to the beneficiaries and obtain resources
Administration	Improve the way teams work together - even in the absence of key individuals by establishing and functionalizing systems	Help manage time and people in a way that is more productive for delivering services
Human resource management	Help attract, retain, support and develop people to do the work and build skills over time	Improve the quality of services and overall capacity for bringing in new people to expand services/intervention
Financial management	Make the system for managing funds safer, more efficient and more transparent	Build/gain trust with donors and stakeholders to take in and effectively mobilize more funds
Organizational/Program management	Help manage organization and programs more professionally/smoothly, including reporting and M&E functions	Improve results and stakeholder satisfaction, enhance quality of services and generate/use lessons learned
Project Performance Management	Allow stakeholders to receive a complete range of higher quality and timely services and support	Strengthen partner organizations and improve partners' reputation among stakeholders
External communications	Helps partners communicate better with clients and involve/integrate them in their work	Help partners, donors and community members to work with each other more easily

The OCAT and the following CD interventions assume that by strengthening several of these basic areas as chosen and prioritized by the implementing partners, we will have the means to improve the way we work in the following key areas:

- Effective service provision
- Making effective referrals
- Communicate with clients more effectively
- Community involvement
- Improving quality of services
- Train/coach/mentor staff
- Technical support to staff
- Using data to inform/support programs

Which in turn will strengthen:

- Outreach to clients
- Behavior change communications
- Drop in services
- Better trained and supported staff with good morale

- Robust monitoring of programs
- Technical quality of programs
- Advocacy efforts

Ultimately, these efforts will pay off by ways of contributing towards the fulfillment of CAP-TB objectives and goals. Some of which are:

- Reduce TB incidence and prevalence in our target population
- Improve rights and policy environment for our beneficiaries
- Improve treatment and care and support outcome for TB/MDR TB patients